Third Party Liability In The Medicaid Program

A Guide To Successful State Agency Practices

HEALTH CARE
FINANCING
ADMINISTRATION

1987 Edition

INTRODUCTION

The subject of this updated Guide is Medicaid Third Party Liability (TPL) Successful Practices. Federal law and regulations require States to assure that Medicaid recipients utilize all resources available to them which can pay for all or part of their medical care needs before turning to Medicaid. This may involve health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more recipients.

The original Guide to Successful State Medicaid Agency Practices in the Third Party Liability Program was published in November 1984. The intent of the researchers and author was to disseminate general information about TPL practices and encourage people working in TPL in different States to communicate with each other and share ideas. The presentations in the original Guide, by design, were not detailed enough to evaluate fully the idea or activity being discussed. The names and addresses of key TPL people in each State were included in the State Reference Data Section so that readers could follow up with these individuals to obtain more detailed information. The researchers and author intended that HCFA update the Guide material at an appropriate time.

When the original Guide was published, regulations at 42 CFR 433.139 provided States with two methods of paying claims that involved third party liability. Under the first method, if the amount of third party liability had been established at the time the claim was submitted, the agency could pay only to the extent that payment allowed under the agency's payment schedule exceeded the amount of available third party liability. This method is "cost avoidance". The second method permitted the agency to pay the total amount allowed under the agency's payment schedule and then to seek reimbursement after the fact from the liable third parties. This is known as the "pay and chase" method. Since that time, however, regulations were published in the Federal Register on November 12, 1985 which require State agencies to use the cost avoidance method of payment anytime the agency has established the probable existence of third party liability at the time a claim is filed. Provision was made for States to request a waiver within a specified period of time which could be approved by the Health Care Financing Administration Regional Offices. Waivers could only be approved for "pay and chase" methodologies already in existence as of November 1985 and which States could demonstrate to be as cost effective as cost avoidance. A recent statutory change has mandated two exceptions to the cost avoidance requirement.

Another change in the TPL program has resulted from regulations published in the Federal Register on February 27, 1987. These regulations require State agencies to attempt to secure agreements with Federal and other State agencies to provide for the collection of health insurance information needed to identify

third party resources. The regulations also require State agencies to conduct data exchanges with Workers Compensation Commissions and Motor Vehicle Accident Report Files to identify those individuals with employment or accident related injuries, and to use diagnosis/trauma code edits for similar purposes.

Because of these statutory and regulatory changes, the need to update statistical data included in the practices, the need for the Guide to reflect revisions to existing practices not caused by statutory and regulatory changes and for the publication to include successful practices developed since the original publication, a team of six individuals involved with TPL at the Federal and State levels was formed to update the Guide. The material in the updated Guide reflects the best information available as of May 1987.

It should be noted that the Guide includes only practices which time has proven effective. Many new and innovative approaches are being taken in various States; however, since the success of these approaches has not yet been measured, such practices have not been included here. We wish to express our sincere appreciation to the States that submitted ideas for successful practices. While all ideas presented were not included in the Guide, each idea contributed information that was useful in the publication of a more complete Guide.

ACKNOWLEDGEMENTS

The Health Care Financing Administration (HCFA) wishes to extend its thanks and appreciation to the Directors and staff of the Third Party Liability Units in all 50 States and the District of Columbia for the time spent in updating the Guide data and for forwarding new ideas and also for discussing their programs with the Guide workgroup.

HCFA also wishes to acknowlege the efforts of the dedicated workgroup members and central office support staff who labored under a tight time frame to publish the Guide. HCFA further wishes to acknowlege the support of the State Third Party Liability Technical Advisory Group, two of whose members made significant contributions to the project.

WORKGROUP MEMBERS

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SECTION I

FEDERAL AND STATE REFERENCE DATA

Part A - Federal Reference Data

1. Health Care Financing Administration's Mission

The Health Care Financing Administration (HCFA) was created by order of the Secretary of Health, Education and Welfare on March 9, 1977, to bring together under one administration the management of the Medicare and Medicaid programs.

HCFA's mission is:

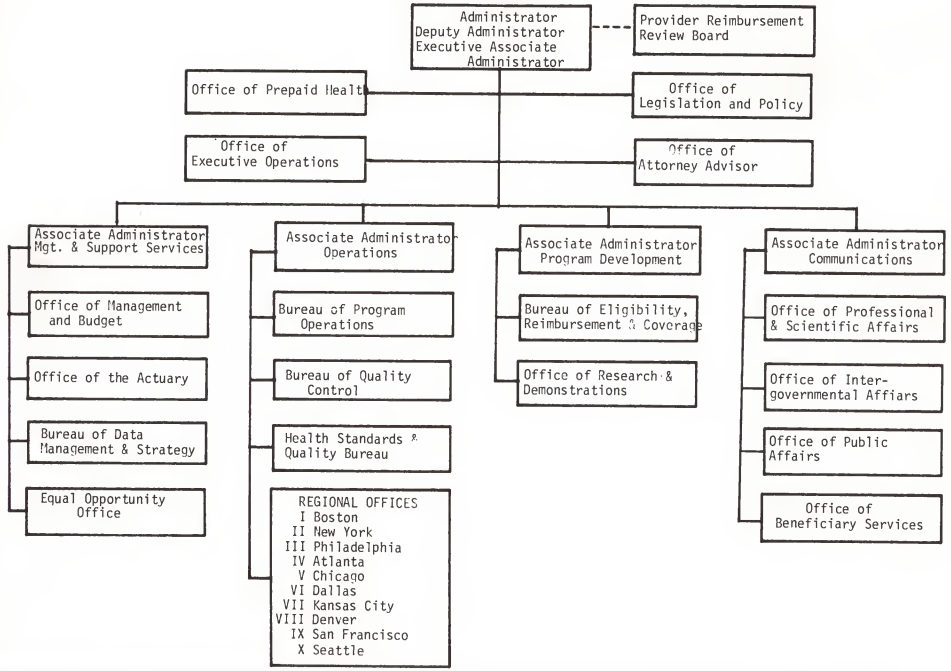
- To ensure the effective administration of its programs in order to promote the timely delivery of appropriate, quality health care to its beneficiaries;
- To make certain that beneficiaries are aware of the services for which they are eligible, that those services are accessible to them and are provided in the most effective manner; and
- To ensure that its policies and actions promote efficiency and quality within the total health delivery system which serves all Americans.

The focal point for Medicaid Third Party Liability operating instructions and policy guidance to Medicaid State agencies and regional offices is the Third Party Liability Branch, Division of Performance Evaluation, Office of Program Review and Evaluation, Bureau of Quality Control.

The law requires that Medicaid be the payor of last resort for claims of medical assistance for its recipients. Because of the large Federal deficit, it is incumbent upon us to utilize every tool at our disposal to contain costs while providing quality health care to Medicaid recipients. Increasing third party liability cost avoidance savings and collections from liable third parties holds great potential for significant savings to both the Federal Government and the States.

Following is a HCFA organizational chart and a brief description of the duties and responsibilities of those components with Medicaid related functions.

HEALTH CARE FINANCING ADMINISTRATION
CENTRAL OFFICE



2. Health Care Financing Administration
Central Office Organization and Functions

Office of Prepaid Health Care

The Office of Prepaid Health Care (OPHC) sets policy and performs studies regarding prepaid health insurance plans for both Medicare and Medicaid. In general, OPHC will conduct studies, provide recommendations for legislation and policy, monitor the implementation of these policies, and measure the effectiveness of prepaid (capitated) health plans.

Office of Legislation and Policy

The primary function of the Office of Legislation and Policy (OLP) is to set, react to, and analyze proposed Medicaid legislation. Analyses are performed to study the effects of existing and proposed legislation on the costs, delivery of service, quality of care, scope of coverage, etc., of the current Medicaid program. OLP also develops regulations for implementing new legislation and responds to a variety of requests for information about the Medicaid program.

Associate Administrator for Management and Support Services

The Associate Administrator for Management and Support Services is responsible for all activities relating to the maintenance of Medicare/Medicaid data, provision of automated data processing (ADP) hardware/software support throughout HCFA, and provision of administrative support, such as personnel management, program and Agency accounting and budgeting, and implementation of the Equal Opportunity program.

Office of the Actuary

The Office of the Actuary (OACT) is responsible for the development and updating of Medicare and Medicaid cost estimates for services provided under the national health programs. In addition, OACT reports on Medicaid services, population served, utilization of the program, and costs of services.

Office of Management and Budget

The Office of Management and Budget (OMB) provides HCFA-wide policy direction, coordination and control in the areas of budget, financial and accounting operations, personnel, management evaluation and analysis, administrative services, project grants, contracting and procurement, and workplanning. It develops and promulgates HCFA policy in these areas and executes these policies throughout HCFA. OMB also designs, implements, maintains, and provides ADP support to HCFA with respect to personnel management systems, financial management systems, and administrative systems; provides clerical and manual support in processing a variety of bill query, enrollment and premium billing transactions; provides analytical support in the development of procedural instructions for the clerical support staff; and directs a correspondence and control staff with respect to inquiries related to health insurance utilization records.

Associate Administrator for Operations

The Associate Administrator for Operations (AAO) has the overall responsibility for setting policy, guidelines, and standards for Medicaid program implementation and financing. Within the AAO, the Bureau of Quality Control (BQC) handles all Medicaid operational and financial issues and policies. This administrative group also includes the Bureau of Program Operations (BPO) which administers the Medicare program, all the regional offices, and another quality control group - the Health Standards and Quality Bureau (HSQB) - which handles peer review organizations (PROs) and institutional survey and certifications.

Bureau of Quality Control

The Bureau of Quality Control is responsible for establishing policies and guidelines for the operation and assessment of State Medicaid programs. The quality assessment programs are Medicaid Eligibility Quality Control (MEQC), Claims Processing Adjustment System (CPAS), Utilization Control (UC) and Systems Performance Review (SPR). These reviews measure the accuracy of eligibility determinations, individual claims payment, institutional utilization, and systems. BQC also reviews the State's compliance with approved Home and Community-Based and Freedom of Choice Waivers, and prepares reports summarizing those data and the results of waiver program reviews. BQC sets guidelines for measuring institutional performance and establishes policy regarding institutional payments. BQC also designs targeted reviews to examine specific aspects of the Medicare and Medicaid programs; these reviews vary from year to year.

BQC develops all procedures, guidelines, and standards for the operation of the Medicaid program, including State plan amendment processing, State program assessment, program accounting, and TPL. In addition, BQC is responsible for assuring implementation of new legislation affecting Medicaid, such as the Income Eligibility, and Verification System (IEVS) and the Systematic Alien Verification of Entitlement program (SAVE).

Health Standards and Quality Bureau

The Health Standards and Quality Bureau (HSQB), among other duties, performs the certification and monitoring of Medicare/Medicaid institutional providers. The Bureau develops policy and procedures for surveying Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Intermediate Care Facilities for the Mentally Retarded (ICF/MR). This bureau also runs the PRO program.

Associate Administrator for Program Development

The Associate Administrator for Program Development oversees two organizations - the Bureau of Eligibility, Reimbursement and Coverage (BERC) and the Office of Research and Demonstrations (ORD). For Medicaid, these organizations are concerned primarily with policy development and researching new ways to implement the program.

Bureau of Eligibility, Reimbursement and Coverage

The Bureau of Eligibility, Reimbursement and Coverage (BERC) develops and issues Federal policy concerning Medicaid eligibility, reimbursement and coverage. BERC also reviews and tracks the status of State plan amendments and initial waiver applications and renewals.

Office of Research and Demonstrations

The Office of Research and Demonstrations (ORD) awards and monitors contracts and grants for conducting research and demonstrations of potential new Medicaid program initiatives. ORD also performs in-house statistical and technical analysis to demonstrate or research new initiatives and prepares reports reflecting these efforts. The results contained in these reports are used by other HCFA components as a basis for proposing legislation and developing policy.

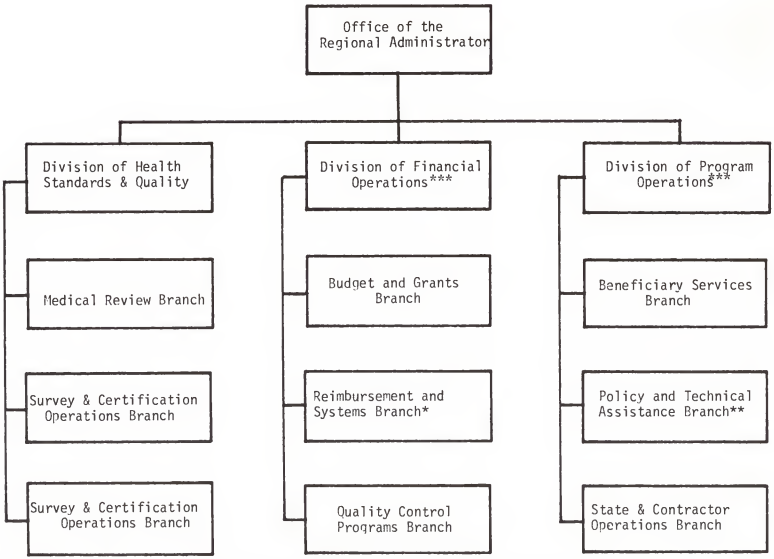
Associate Administrator for Communications (AAC)

This organization develops policy and guidelines for and acts as a liaison with agencies external to HCFA concerning the Medicaid program. AAC acts as a liaison between and among States, HCFA Regional Offices, HCFA Central Office, providers, special interest groups, and other governmental agencies in reviewing policy and regulations, implementing new program initiatives, and implementing the Medicaid program.

Office of Intergovernmental Affairs (OIA)

The Office of Intergovernmental Affairs represents HCFA in policy negotiations with the State Medicaid agencies and acts as a conduit from the States to HCFA in disallowance cases and appeals of denied waivers.

HEALTH CARE FINANCING ADMINISTRATION
REGIONAL OFFICES



* The Atlanta, Chicago and San Francisco ROs have a Reimbursement & Recovery Branch and a separate Systems Branch.
** The Denver and Seattle ROs have eliminated the Policy and Technical Assistance Branch.
*** The Denver and Philadelphia ROs have replaced the Division of Financial Operations and Division of Program Operations with the Divisions of Medicare and Medicaid.

Regional Office Medicaid Functions

There are ten HCFA Regional Offices: Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco and Seattle. Each Office consists of three Divisions that monitor and support the Medicaid programs in the States within the region. These Divisions (in the majority of regions) are: the Division of Health Standards and Quality (DHSQ), the Division of Financial Operations (DFO), and the Division of Program Operations (DPO). At the branch level, within Divisions, staff are organized differently from region to region. In addition, in the Philadelphia and Denver Regional Offices, the three Divisions are: DHSQ, the Medicaid Division and the Medicare Division.

The chief executive in the region, the Regional Administrator, needs accurate and timely Medicaid information since he is responsible for efficient Medicaid program administration within the region and must respond to inquiries presented to the regional office. The following sections describe the functions of the three major regional office components and their Medicaid data needs.

Division of Health Standards and Quality

The Division of Health Standards and Quality is responsible for monitoring and reviewing the quality of health care provided in the region by both the Medicare and Medicaid programs. Certification of new providers for both Medicaid and Medicare is handled by this Division, which also monitors and examines the results of State surveys performed on long term care institutions. This component also has responsibility for all policies and operational issues pertaining to PROs.

Division of Financial Operations

The Division of Financial Operations performs all quality control and financial reviews of State Medicaid operations. This Division conducts the SPR on the State Medicaid Management Information Systems (MMIS) with the assistance of the Division of Program Operations, processes HCFA-64s and HCFA-25s, and performs State agency financial audits. Grant award recommendations are sent to the central office from this division and implemented waiver programs are reviewed for financial feasibility.

Division of Program Operations

The major Medicaid function of the Division of Program Operations is to monitor and guide State agency operation of the Medicaid program. This division also processes and reviews waiver applications and State Plan amendments and reports on the status of these documents to central office. Most of the TPL activity within the regions is focused in DPO as evidenced by the following list of current regional TPL coordinators.

HEALTH CARE FINANCING ADMINISTRATION

Regional Medicaid Third Party Liability Coordinators

Region	Contact	Address	Telephone No.
Boston (I)	Bob Bavelock	Division of Program Operations Room 1309 JFK Federal Building Boston, Massachusetts 02203	FTS 8-835-1257 (617) 565-1257
New York (II)	Steve Shaw	Division of Program Operations Room 3811 26 Federal Plaza New York, New York 10278	FTS 8-264-4459 FTS 8-264-2590 (212) 264-4459 (212) 264-2590
Philadelphia (III)	Ken Albrecht	Division of Program Operations 3535 Market Street P. O. Box 7760 Philadelphia, Pennsylvania 19101	FTS 8-596-6857 (215) 596-6857
Atlanta (IV)	Lance Villard	Division of Program Operations Suite 701 101 Marietta Tower Atlanta, Georgia 30323	FTS 8-242-0142 (404) 331-0142
Chicago (V)	Kathy Penak	Division of Program Operations Suite A-835 175 West Jackson Boulevard Chicago, Illinois 60604	FTS 8-353-9860 (312) 353-9860
Dallas (VI)	James Oge	Division of Program Operations Room 2000 1200 Main Tower Building Dallas, Texas 75202	FTS 8-729-6441 (214) 767-6441
Kansas City (VII)	Judith Flynn	Division of Program Operations New Federal Office Building Room 235 601 East 12th Street Kansas City, Missouri 64106	FTS 8-758-3406 (816) 374-3406
Denver (VIII)	Dave Selleck	Division of Program Operations Federal Building Room 574 1961 Stout Street Denver, Colorado 80294	FTS 8-564-6216 (303) 844-6216
San Francisco (IX)	Bob Kovash Langford Williams	Division of Program Operations 14th Floor 100 Van Ness Avenue San Francisco, California 94102	FTS 8-556-2191 (415) 556-2191
Seattle (X)	Denny Sexton Lavinia Peters	Division of Financial Operations Mail Stop 502 2901 Third Avenue Seattle, Washington 98121	FTS 8-398-8140 FTS 8-399-8154 FTS 8-399-7807 (206) 442-8140

SECTION - I

FEDERAL AND STATE REFERENCE DATA

Part B - State Reference Data

CONTACT PERSON

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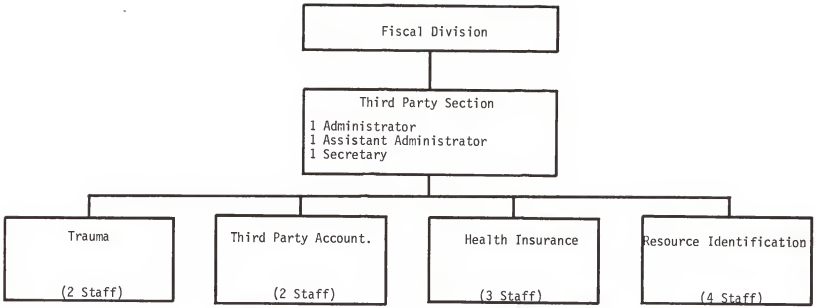
Alabama Medicaid Agency
Third Party Section
2500 Fairlane Drive
Montgomery, AL 36130
(205) 277-2710

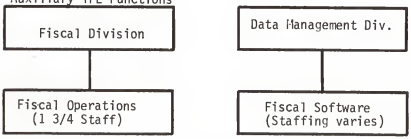
STATISTICS: (SFY 86)

# of Recipients	306,070
Total Annual MA Payments	$494.82 M
Annual State MA Payments	$139.75 M

ALABAMA



Auxiliary TPL Functions



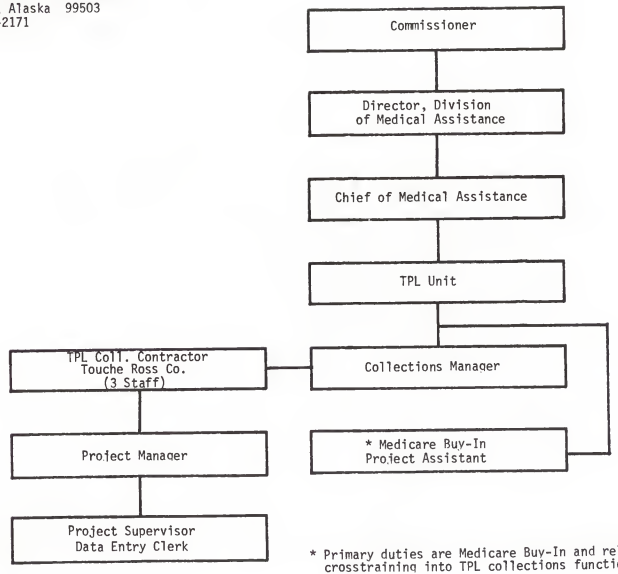
CONTACT PERSON

Joe Skrzypek
TPL Collections Manager
Department of Health & Social Services
Division of Medical Assistance
4041 "B" Street - Suite #101
Anchorage, Alaska 99503
(907) 561-2171

ALASKA

STATISTICS - FY 1987

# Recipients	29,895
Total Annual MA Payments	$72 M
Annual State MA Payments	$36 M



* Primary duties are Medicare Buy-In and related functions crosstraining into TPL collections functions.

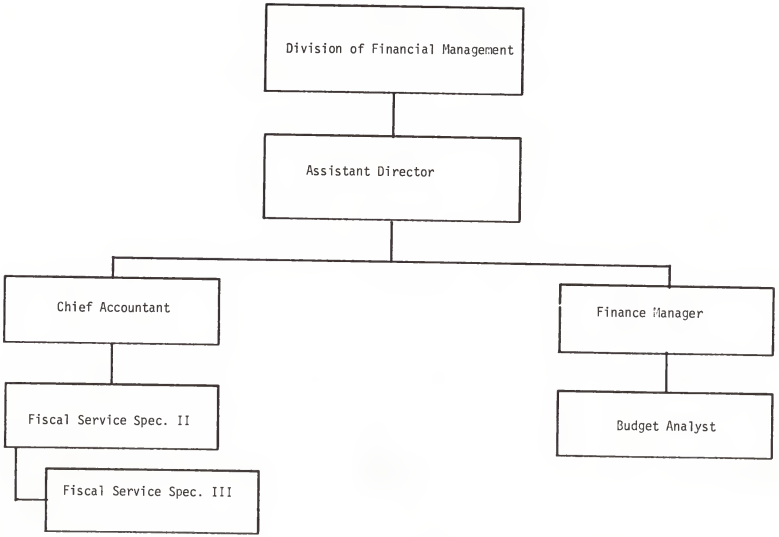
CONTACT PERSON

Ms. Dee Alex, Manager
Fiscal Recovery Unit
Health Care Cost Containment System
301 East Jefferson Street
Phoenix, AZ 85034
(602) 234-3655, Ext. 4095

STATISTICS: (SFY 85-86)

# of Recipients	127,141
Total Annual MA Payments	$115 M
Annual State MA Payments	$ 41.7 M

ARIZONA



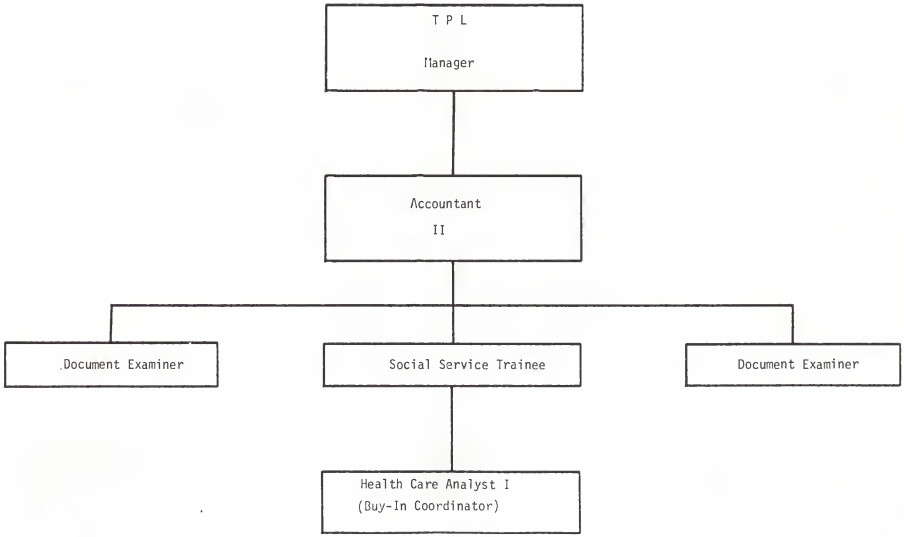
CONTACT PERSON

Mr. Walt Patterson, Deputy Dir.,
Division of Economic and
Medical Services
Department of Human Services
Little Rock, AR 72203
(501) 371-2321

STATISTICS: (SFY 86)

# of Recipients	203,342
Total Annual MA Payments	$423 M
Annual State MA Payments	$112 M

ARKANSAS



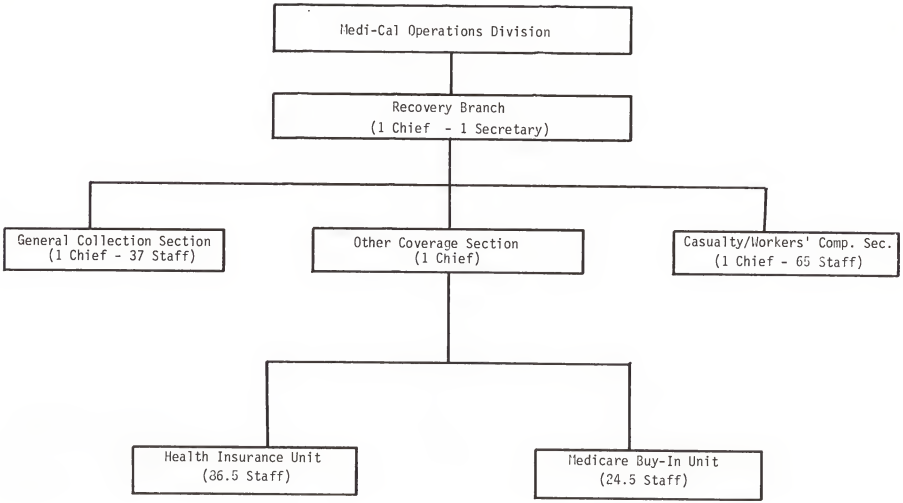
CONTACT PERSON

Gerald Rohlfes, Chief
Recovery Branch
1250 Sutterville Road, Room 201
Sacramento, California 95822
(916) 445-0416

STATISTICS: (SFY 86)

# of Recipients	2.97 M
Total Annual MA Payments	$5.1 B
Annual State MA Payments	$2.5 B

CALIFORNIA



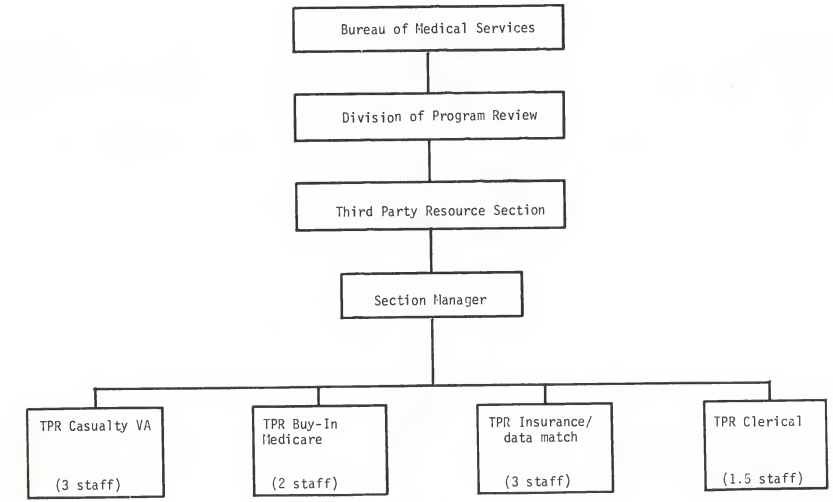
CONTACT PERSON

Janell Little, Manager
Third Party Resource Section
Division of Program Review
Bureau of Medical Services
Department of Social Services
P.O. Box 181000
Denver, Colorado 80218-0399
(303) 294-2575

STATISTICS: (SFY 87)

# of Recipients	133,000
Total Annual MA Payments	$ 331 M
Annual State MA Payments	$ 166 M

COLORADO



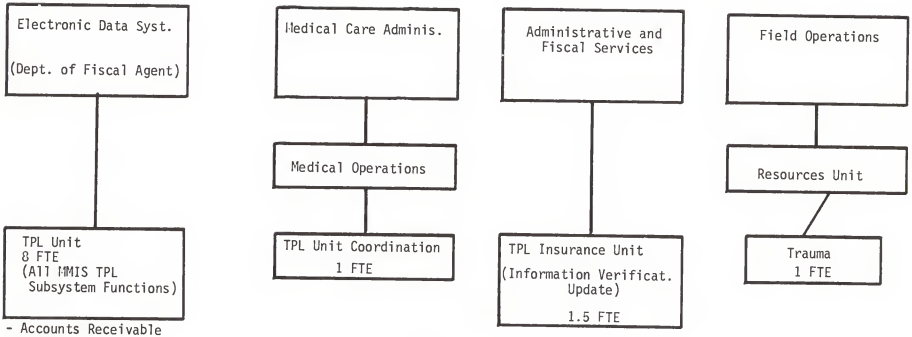
CONTACT PERSON

Walter King
Dept. of Income Maintenance
Third Party Liability
110 Bartholomew Avenue
Hartford, CT. 06106
(203) 566-7055

STATISTICS: (SFY 86)

# of Recipients	103,628
Total Annual MA Payments	$672.6 M
State Annual MA Payments	$336.7 M

CONNECTICUT



- Accounts Receivable
- Audit
- Billing
- Edits
- Insurance
- Reporting
- Research
- Trauma

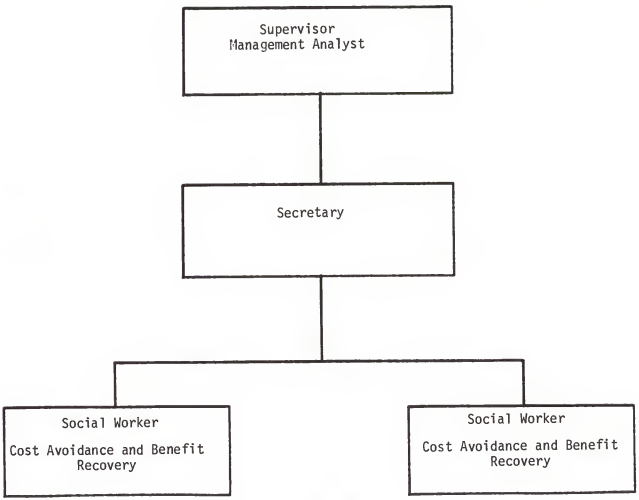
CONTACT PERSON

David Michalik, Management Analyst
TPL Unit
Medical Assistance Program
P.O. Box 906
New Castle, DE 19720
(302) 421-6133

STATISTICS: (SFY 85-86)

# of Recipients	40,000
Total Annual MA Payments	$34 M
Annual State MA Payments	$42 M

DELAWARE



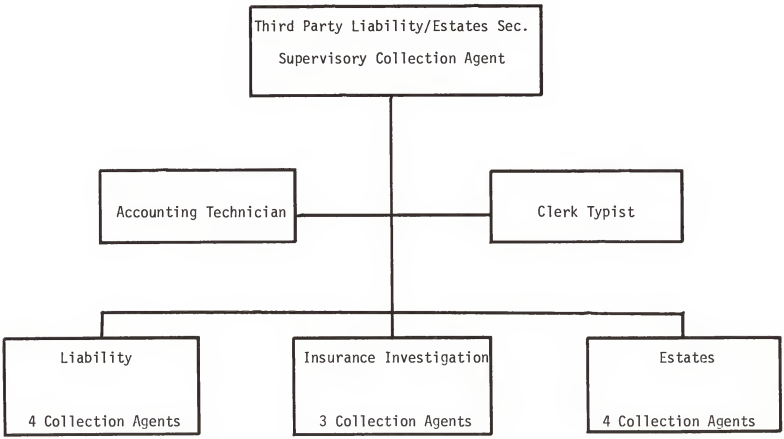
CONTACT PERSON

Bobbie W. Burroughs-McManus, Chief
Third Party Liability/Estates Section
1170 12th Street, N.W., Room 310
Washington, D.C. 20005-4690
(202) 724-5284

STATISTICS: (SFY 86)

# of Recipients	96,651
Total Annual MA Payments	$322 M
Annual State MA Payments	$161 M

WASHINGTON, D.C.



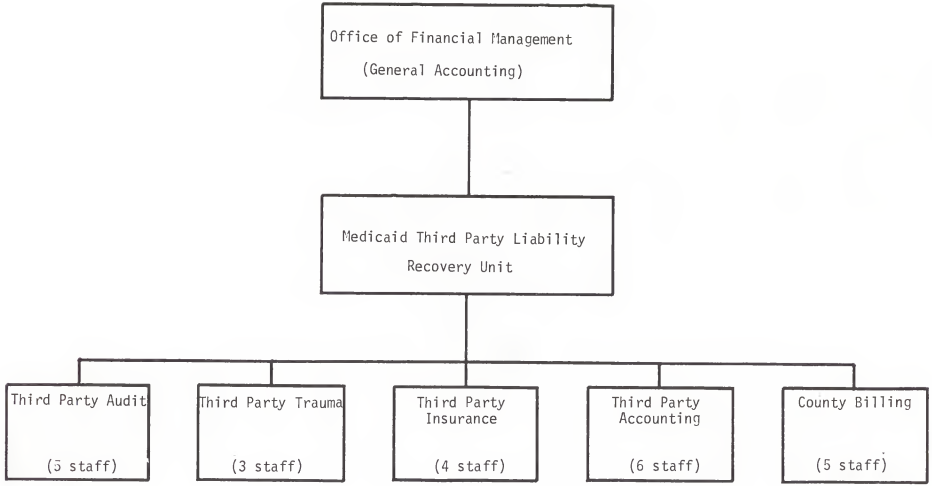
CONTACT PERSON

Ernest O. Alexander, Manager
Medicaid Third Party Recovery
Department of Health and
Rehabilitative Services
1317 Winewood Boulevard
Room 405
Tallahassee, Florida 32399-0700

FLORIDA

STATISTICS: (SFY 86)

# of Recipients	513,000
Total Annual MA Payments	$ 1.1 B
Annual State MA Payments	$466.7 M



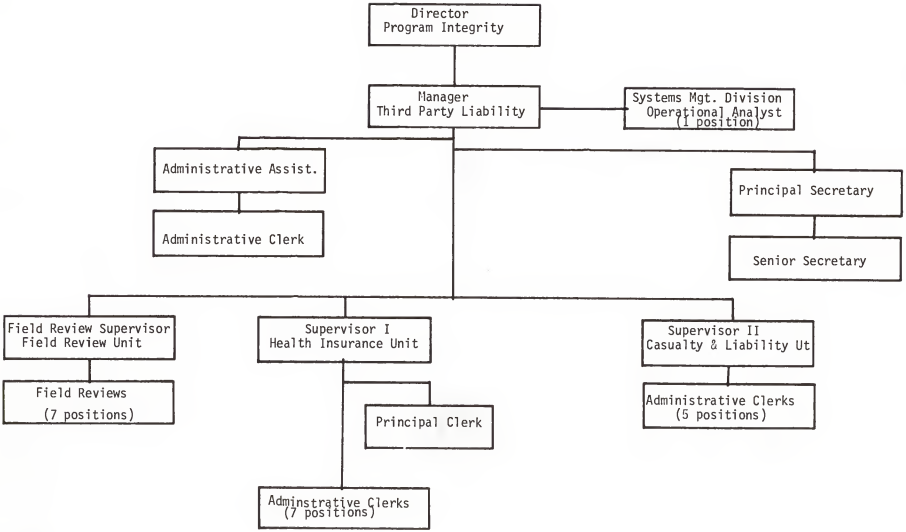
CONTACT PERSON

Rebecca C. Dettra, Manager
Georgia Department of Medical Assistance
Third Party Liability Section
P.O. Box 38439
Atlanta, Georgia 30334
(404) 656-4478

STATISTICS: (SFY 86)

# of Recipients	433,514
Total Annual MA Payments	$859.17 M
Annual State MA Payments	$294.5 M

GEORGIA



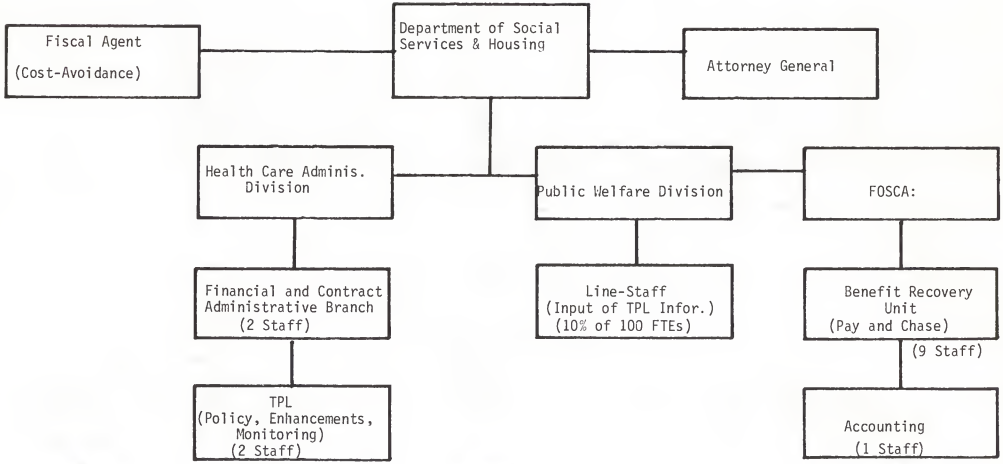
CONTACT PERSON

Mr. Walter Murakami
Coordinator, TPL Unit
Medical Care Adm. Office
Department of Social Services
and Housing
P.O. Box 339
Honolulu, HI 96809
(808) 543-6503

STATISTICS: (SFY 86)

# of Recipients	88,901
Total Annual MA Payments	$149.2 M
Annual State MA Payments	$ 71.7 M

HAWAII



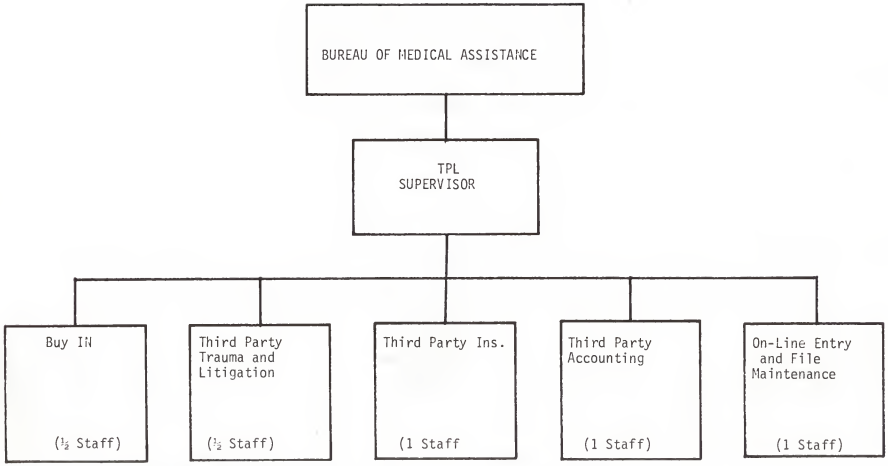
CONTACT PERSON

Dee Anne Wisner
TPL Supervisor
Department of Health and Welfare
Bureau of Medical Assistance
Statehouse Mail
Boise, ID 83720
(208) 334-5738

STATISTICS: (SFY 87)

# of Recipients	45,683
Total Annual MA Payments	$85,961,631
Annual State MA Payments	$25,100,796

IDAHO



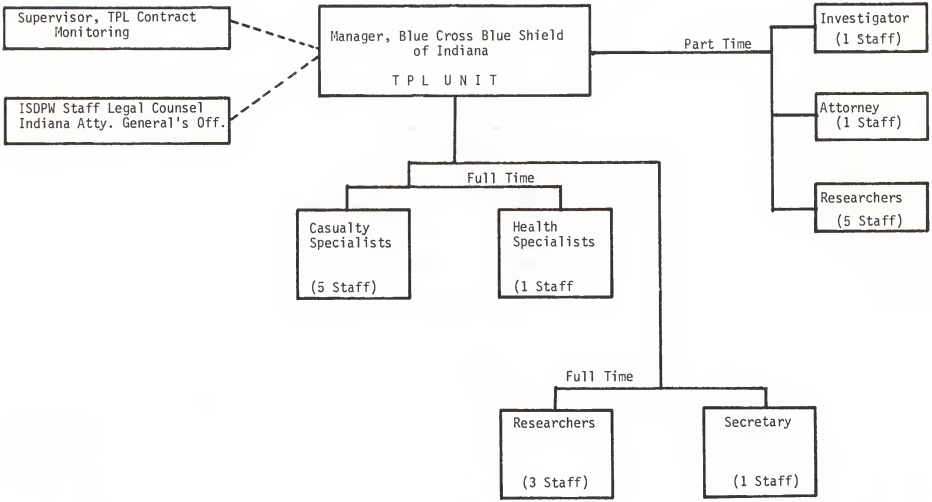
CONTACT PERSON

Valerie Loeffler
Department of Public Welfare
North Senate Avenue - Room 701
Indianapolis, Indiana 46204
(317) 232-4750

STATISTICS: (SFY 86)

# of Recipients	297,755
Total Annual MA Payments	$828 M
Annual State MA Payments	$308 M

INDIANA



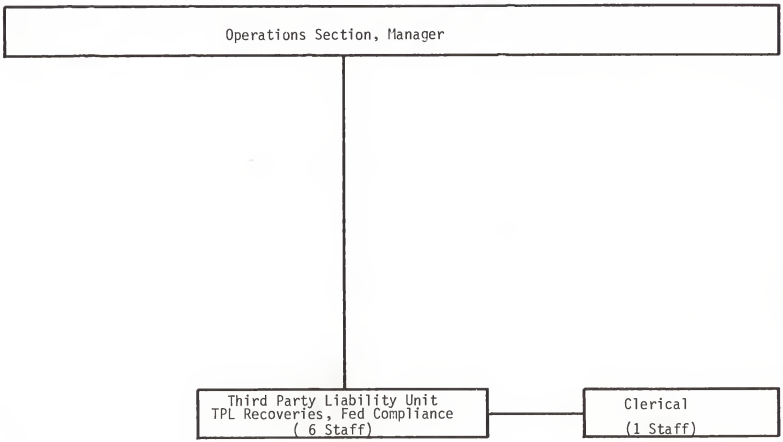
CONTACT PERSON

Mr. Stan Monroe, Supervisor
TPL Unit
Bureau of Medical Services
Hoover State Office Building, 5th Flr.
Des Moines, IA 50319
(515) 281-8433

STATISTICS: (SFY 87)

# of Recipients	221,905
Total Annual MA Payments	$374 M
Annual State MA Payments	$154 M

IOWA



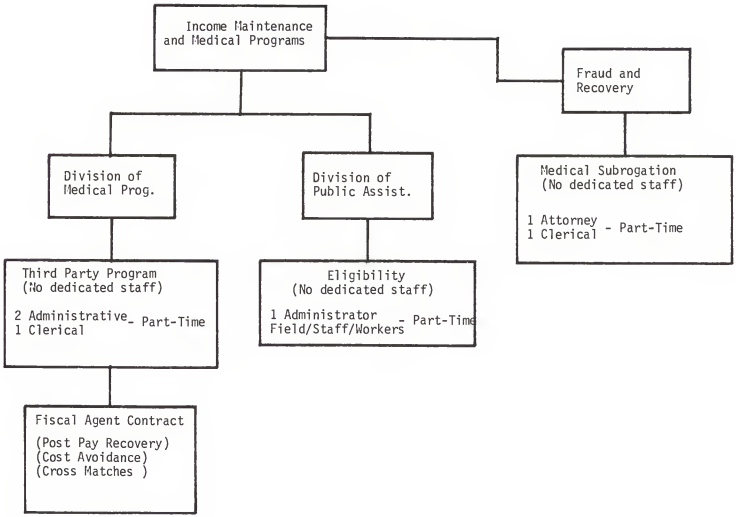
CONTACT PERSON

Katherine E. Hauck
Division of Medical Programs
Docking State Office Building, 623-S
Topeka, KS 66612
(913) 296-3931

STATISTICS: (SFY 86)

# Recipients	120,000
Total Annual MA Payments	$235 M
Annual State MA Payments	$115 M

KANSAS



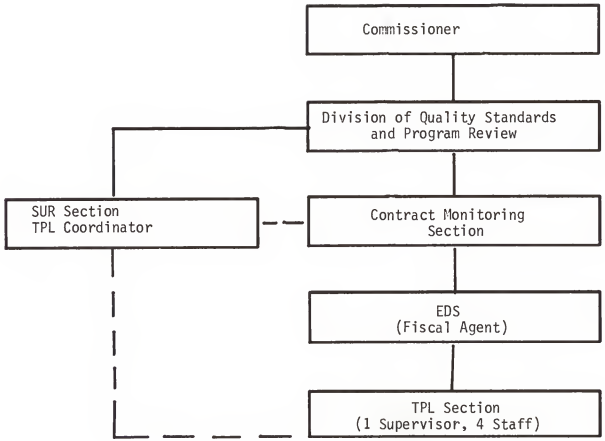
CONTACT PERSON

Cherilynn D. Reagan
Supervisor, SUR Section
Department for Med. Svs.
275 East Main Street
Frankfort, KY 40621
(502) 564-5560

STATISTICS: (SFY 86)

# of Recipients	342,000
Total Annual MA Payments	$574.6 M
Annual State MA Payments	$169.6 M

KENTUCKY



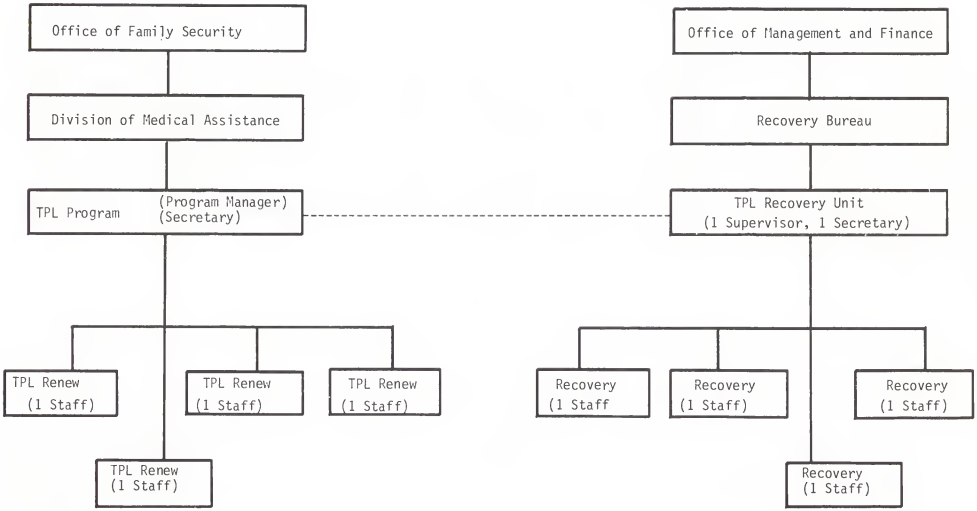
CONTACT PERSON

Montez LeGrande
TPL Program Manager
Office of Family Security
P.O. Box 94065
Baton Rouge, LA 70804
(504) 342-3943

STATISTICS: (SFY 36)

# of Recipients	505,283
Total Annual MA Payments	$757.5 M
Annual State MA Payments	$303 M

LOUISIANA



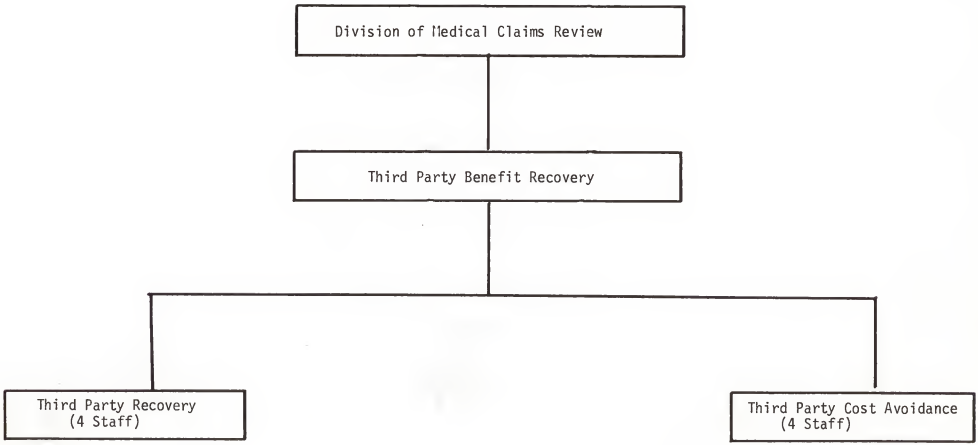
CONTACT PERSON

Ford Powell
Department of Human Services
Third Party Benefit Recovery
221 State Street
Augusta, Maine 04330
(207) 289-3081

MAINE

STATISTICS: (SFY 86)

# of Recipients	114,000
Total Annual MA Payments	$242 M
Annual State MA Payments	$ 77 M



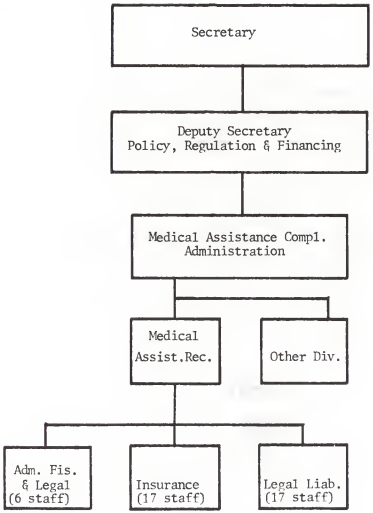
CONTACT PERSON

Lawrence R. Payne, Director
Medical Assistance
Compliance Administration
300 West Preston Street
Baltimore, Maryland 21201
(301) 225-1582

STATISTICS: (SFY 85)

# of Recipients	340,000
Total Annual MA Payments	$666 M
Annual State MA Payments	$387 M

MARYLAND



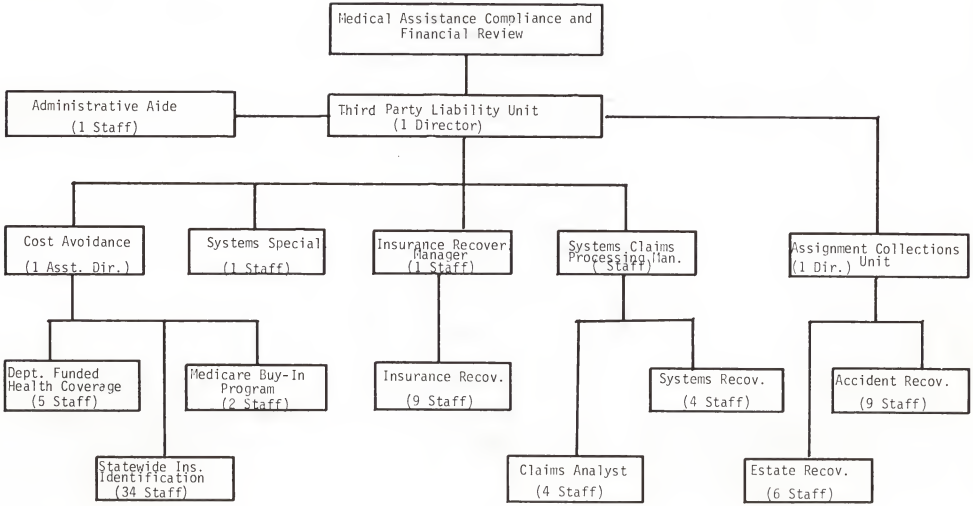
CONTACT PERSON

John Robertson
Department of Public Welfare
Director TPL Unit
P.O. Box 63
Essex Station
Boston, MA 02112
(617) 348-5316

STATISTICS: (SFY 86)

# of Recipients	429,000
Total Annual MA Payments	$ 1.383 B
Annual State MA Payments	$691 M

MASSACHUSETTS



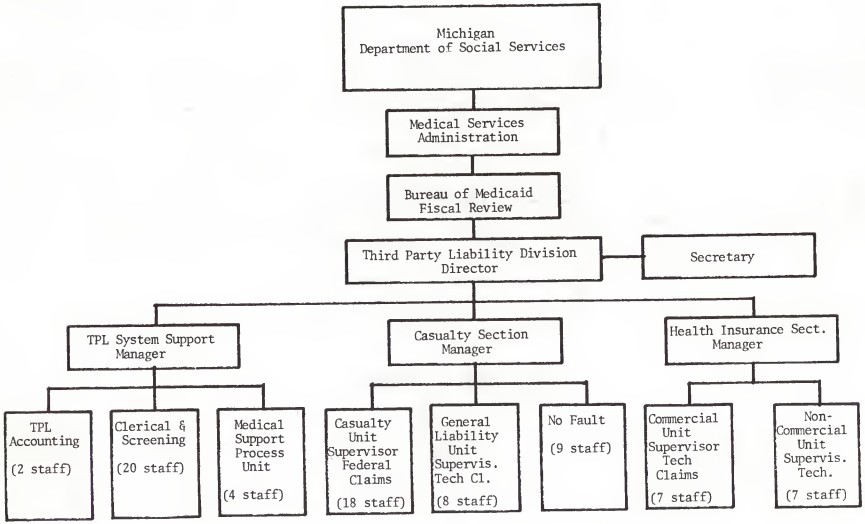
CONTACT PERSON

Seth A. Whitmarsh, Director
Third Party Liability Division
Medical Services Division
Michigan Department of Social Services
921 West Holmes Road
Lansing, Michigan 48910
(517) 334-7405

STATISTICS: (SFY 86)

# of Recipients	1.1 M
Total Annual MA Payments	$ 1.1 B
Annual State MA Payments	$798.8 M

MICHIGAN



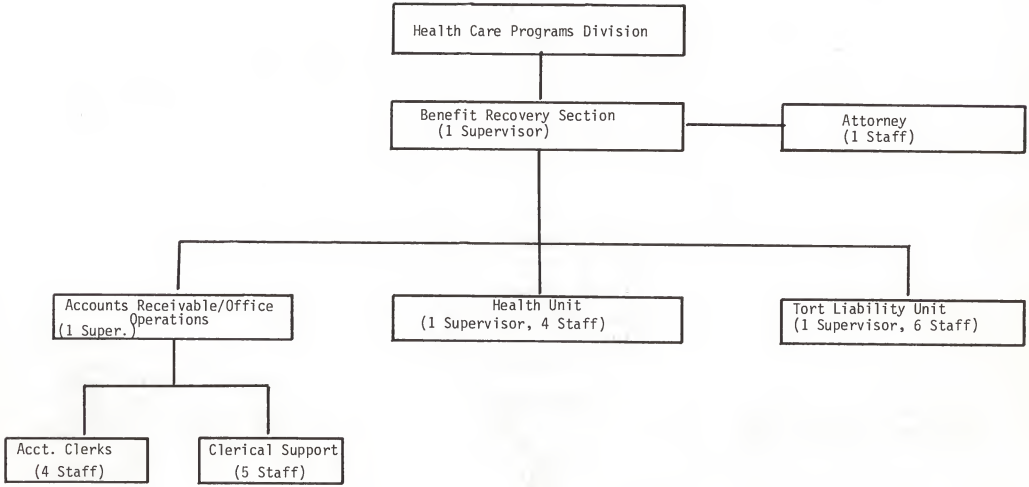
CONTACT PERSON

Jan Taylor
Benefit Recovery Manager
Department of Human Services
444 Lafayette Road
St. Paul, MN 55101
(612) 296-6964

STATISTICS: (SFY 86)

# of Recipients	270,418
Total Annual MA Payments	$ 1 B
Annual State MA Payments	$437 M

MINNESOTA



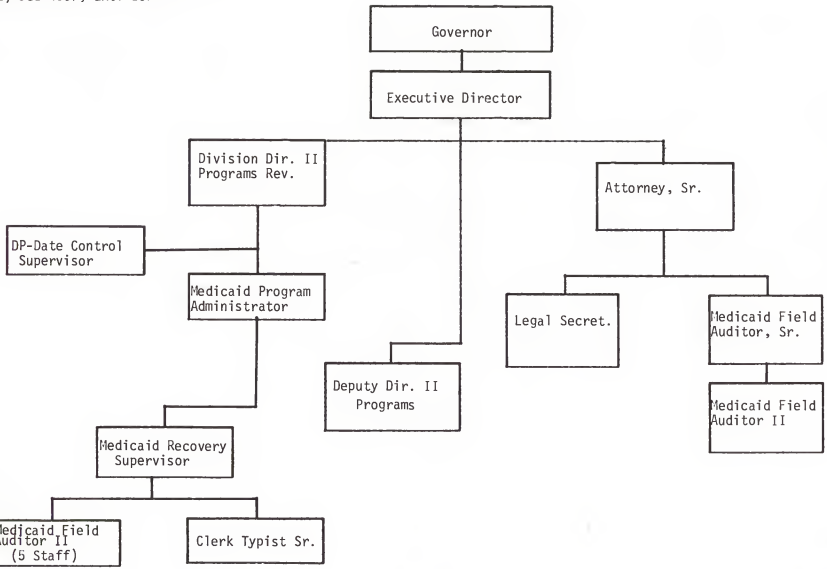
CONTACT PERSON

Nancy Spencer
Medicaid Programs Administrator
Division of Medicaid
P.O. Box 16786
Jackson, Mississippi 39236-0736
(601) 981-4507, Ext. 167

MISSISSIPPI

STATISTICS: (SFY 86)

# of Recipients	236,644
Total Annual MA Payments	$341 M
Annual State MA Payments	$ 74 M



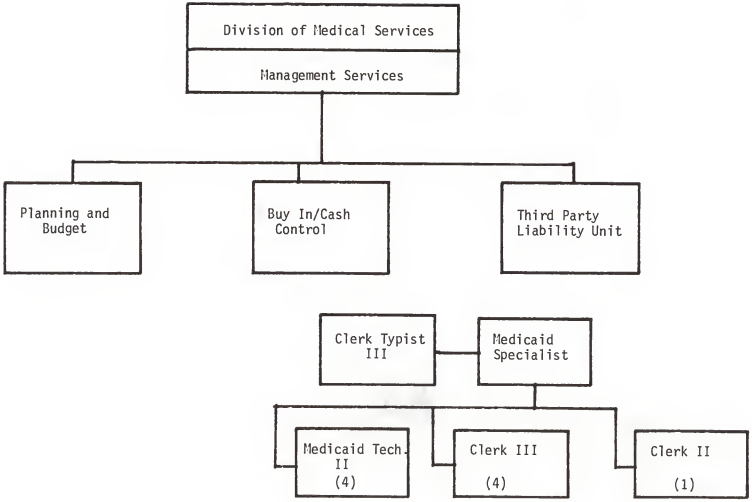
CONTACT PERSON

Carolyn L. Link, Supervisor
Third Party Liability Unit
Management Services
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri
65102-6500
(314) 751-2005

MISSOURI

STATISTICS: (SFY 36)

# of Recipients	295,354
Total Annual MA Payments	$474.5 M
Annual State MA Payments	$207.9 M



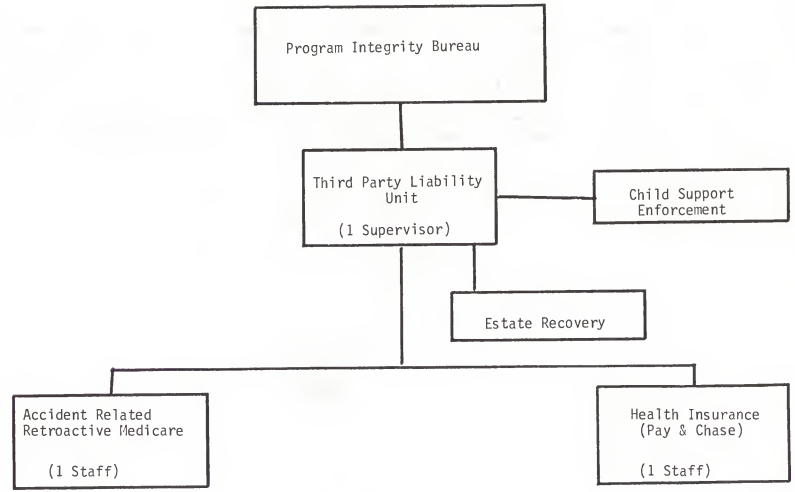
CONTACT PERSON

Terry Frisch
Supervisor
Third Party Liability Unit
Department of Social and
Rehabilitative Services
Box 4210
Helena, MT 59604
(406) 444-4550

STATISTICS: (SFY 87)

# of Recipients	40,000
Total Annual MA Payments	$110 M
Annual State MA Payments	$ 36.3 M

MONTANA



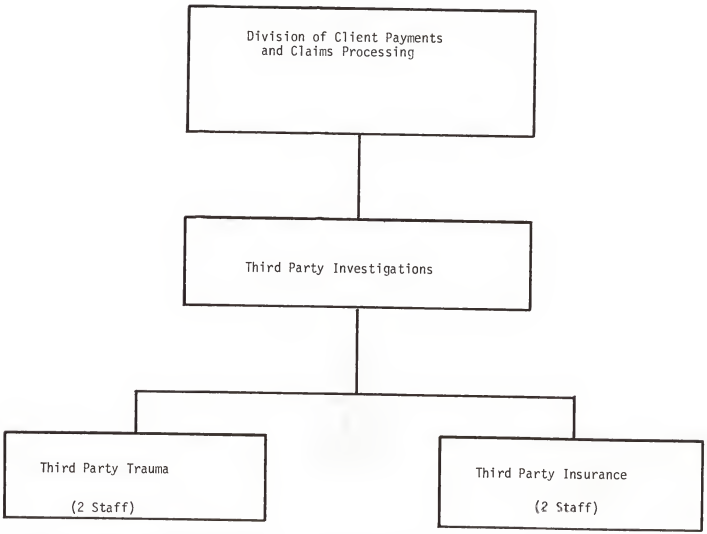
CONTACT PERSON

Emil Spicka
Nebraska Department of Social Services
Third Party Investigations
P.O. Box 95026
Lincoln, Nebraska 68509-5026
(402) 471-9314

STATISTICS: (SFY 87)

# of Recipients	102,051
Total Annual MA Payments	$118.9 M
Annual State MA Payments	$ 80.7 M

NEBRASKA



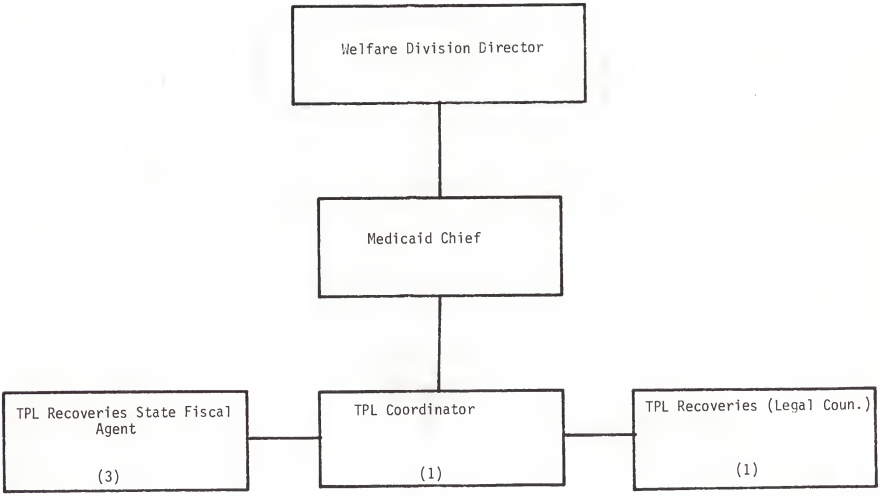
CONTACT PERSON

Ms. Lynn Weaver, Analyst
Med/Care Sec., Welfare Div.
Dept. of Human Resources
2527 N. Carson Street
Carson City, Nevada 89710
(702) 885-4355

STATISTICS: (FY 36)

# of Recipients	32,545
Total Annual MA Payments	$ 5.4 M
Annual State MA Payments	$42.1 M

NEVADA



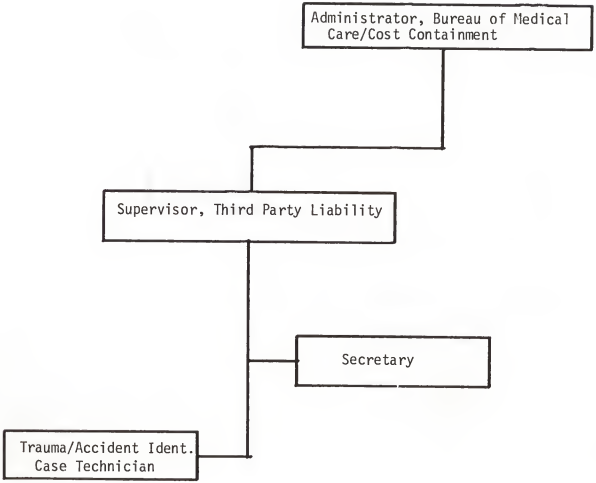
CONTACT PERSON

Susan Hebert
Supervisor, TPL
Division of Human Services
Office of Medical Services
6 Hazen Drive
Concord, N.H. 03301-6521

STATISTICS: (SFY 36)

# of Recipients	35,350
Total Annual MA Payments	$153 M
Annual State MA Payments	$ 67.2M

NEW HAMPSHIRE



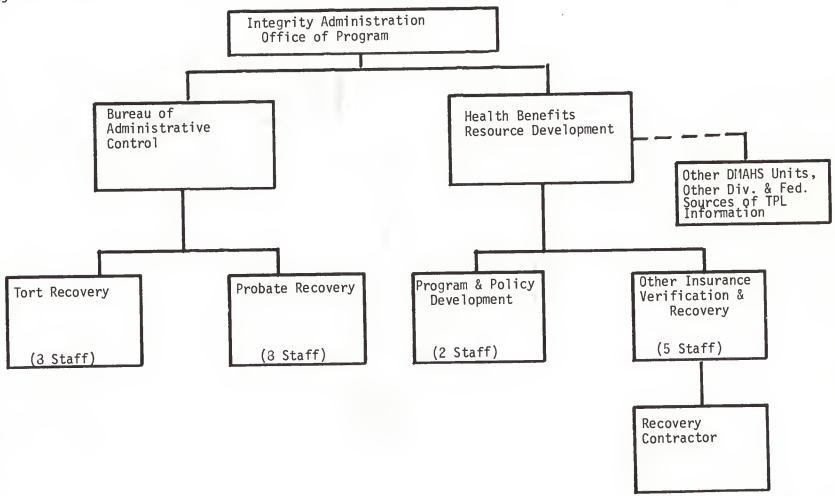
CONTACT PERSON

Murray Goldberg, Chief
Third Pary Liability Programs
Division of Medical Assistance
and Health Services
CN 712
12 Quakerbridge Plaza
Trenton, New Jersey 08625
(609) 588-3039

STATISTICS: (SFY 36)

# of Recipients	581,211
Total Annual MA Payments	$ 1.28 B
Annual State MA Payments	$637.38 M

NEW JERSEY



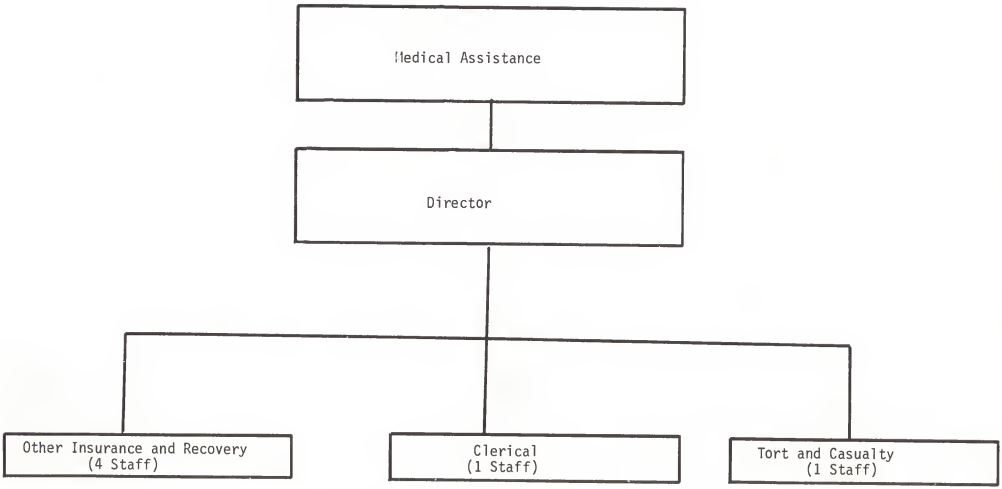
CONTACT PERSON

F. Richard Atkinson
Director, Third Party Liability
Medical Assistance Programs
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2343
(505) 827-4322

STATISTICS: (SFY 87)

# of Recipients	91,846
Total Annual MA Payments	$169.76 M
Annual State MA Payments	$ 51.473M

NEW MEXICO



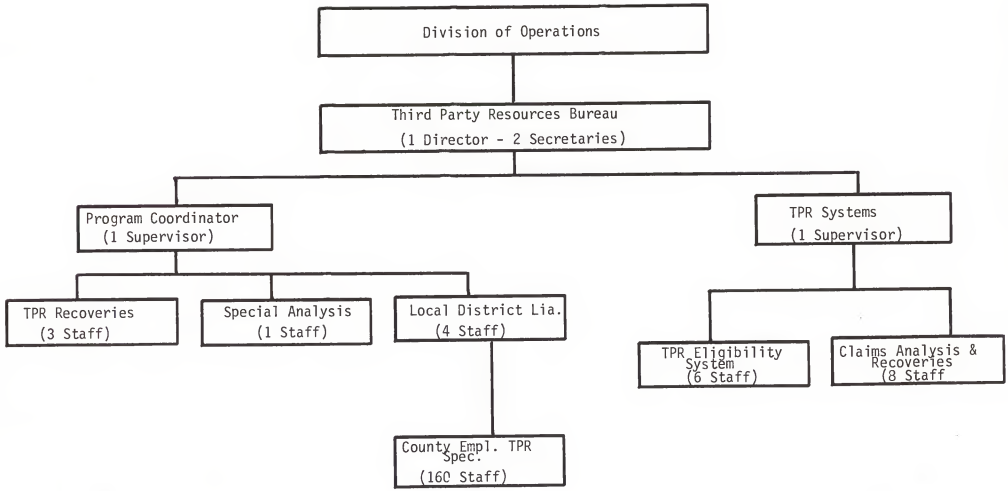
CONTACT PERSON

Ken Buzzard
Department of Social Services
Third Party Resources
P.O. Box 1935
Albany, New York 12201
(518) 474-9193

STATISTICS: (SFY 86)

# of Recipients	2.1 M
Total Annual MA Payments	$6.3 B
Annual State MA Payments	$3.1 B

NEW YORK



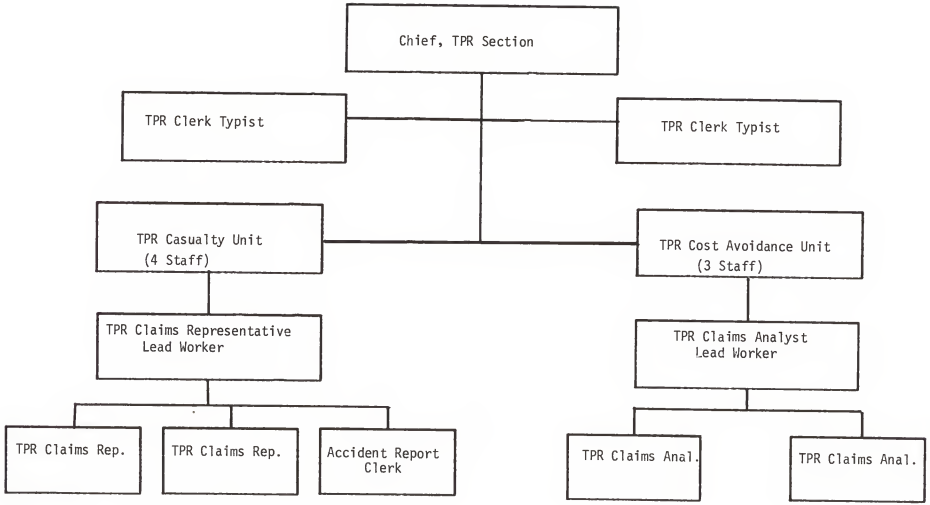
CONTACT PERSON

Donald J. Best, Chief
Third Party Recovery Section
Division of Medical Assistance
1985 Umstead Drive
Raleigh, North Carolina 27603
(919) 733-6294

NORTH CAROLINA

STATISTICS: (SFY 86)

# of Recipients	450,000
Total Annual MA Payments	$792.3 M
Annual State MA Payments	$248.2 M



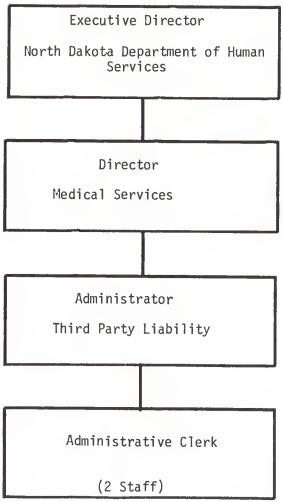
CONTACT PERSON

Ray Fieste
Medicaid Fraud and Abuse
Medical Services
Department of Human Services
State Capitol Building
Bismarck, ND 58505
(701) 224-4024

STATISTICS: (SFY 86)

# of Recipients	40,150
Total Annual MA Payments	$117.79 M
Annual State MA Payments	$ 52.99 M

NORTH DAKOTA



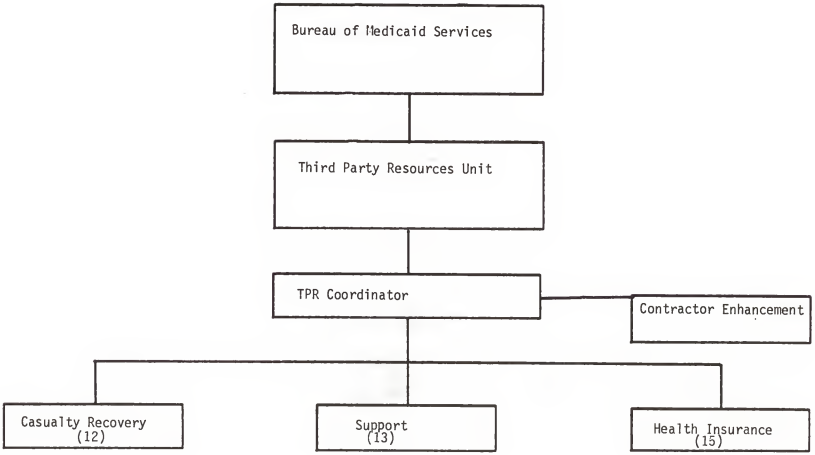
CONTACT PERSON

Heyward W. Riley, Chief
Bureau of Medicaid Services
State Office Tower
30 E. Broad Street
37th Floor
Columbus, Ohio 43266-0423
(614) 466-8427

STATISTICS: (SFY 86)

# of Recipients	890,000
Total Annual MA Payments	$ 2.1M
Annual State MA Payments	$861.4M

OHIO



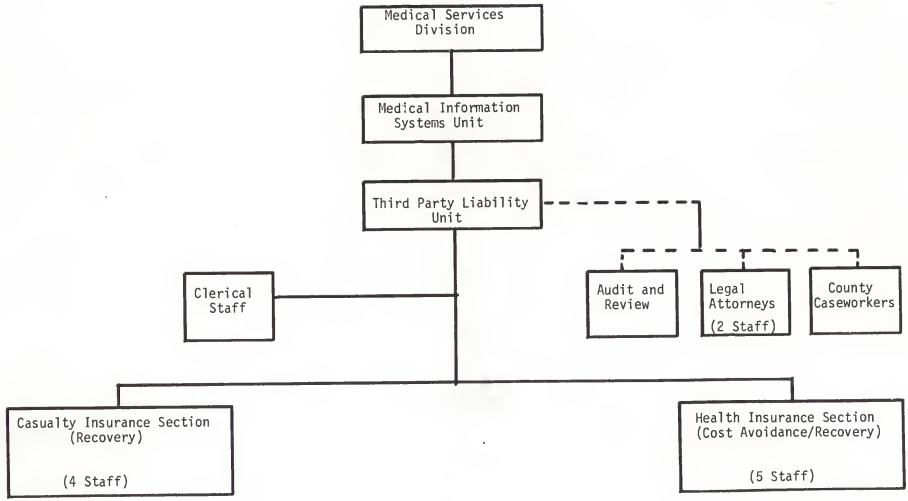
CONTACT PERSON

Robert Jones
Program Supervisor
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-3553

STATISTICS: (SFY 86)

# of Recipients	190,187
Total Annual MA Payments	$447.59 M
Annual State MA Payments	$202.50 M

OKLAHOMA



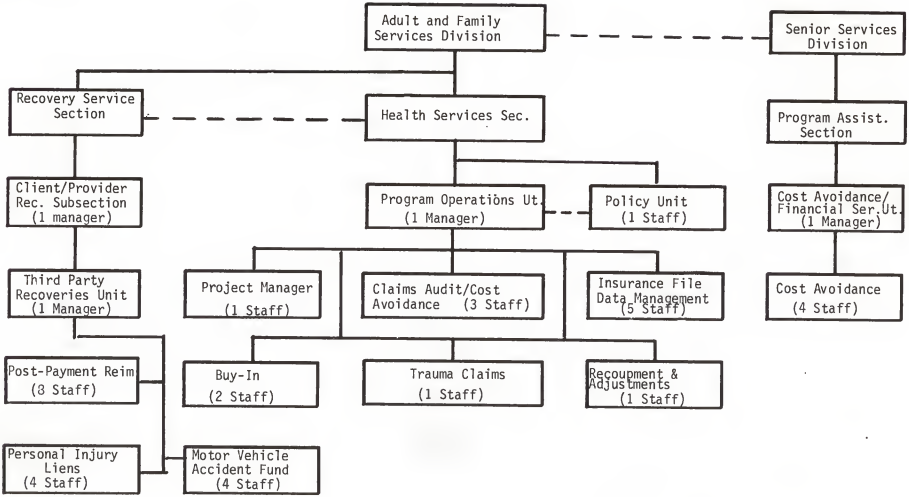
CONTACT PERSON

Marilee Teller
Manager, Programs Operatons Unit
Health Service Section
Adult and Family Services Division
Public Service Building, Room 212
Salem, Oregon 97310
(503) 378-2850

OREGON

STATISTICS: (SFY 86)

# of Recipients	133,000
Total Annual MA Payments	$126 M
Annual State MA Payments	$ 55 M



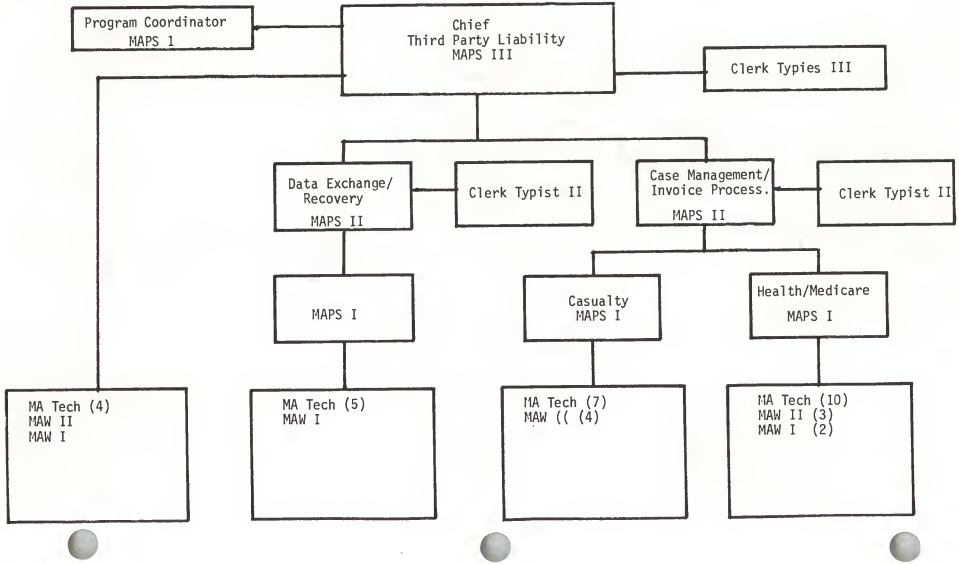
CONTACT PERSON

Judy A. Lininger
Park Penn Building
5101 Jonestown Road
Harrisburg, Pennsylvania 17112
(717) 657-4022

STATISTICS: (SYF 86)

# of Recipients	1.1M
Total Annual MA Payments	$2.2 B
Annual State MA Payments	$1.1 B

PENNSYLVANIA



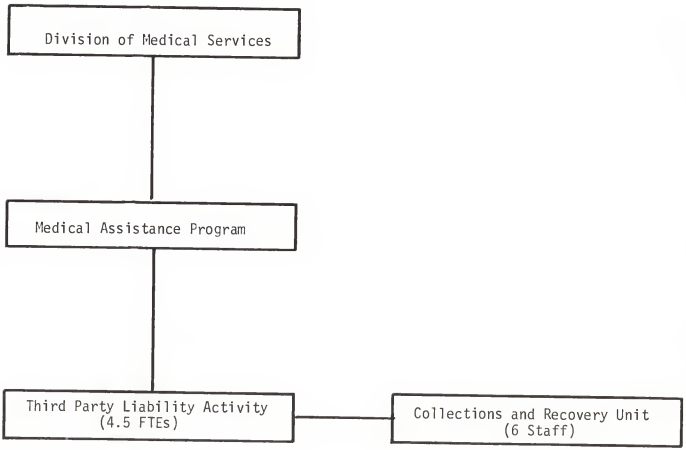
CONTACT PERSON

Frank Spinelli
Sr. Medical Care Specialist
Department of Human Services
Division of Medical Services
Medical Assistance Program
500 New London Avenue
Cranston, RI 02920
(401) 464-2131

STATISTICS: (SFY 86)

# of Recipients	79,525
Total Annual MA Payments	$263.60 M
Annual State MA Payments	$117.30 M

RHODE ISLAND

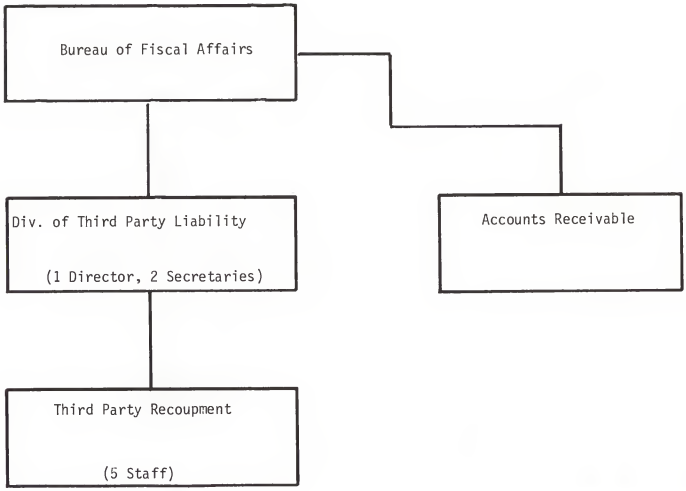


CONTACT PERSON

Calvin W. Nesbit
Director, Third Party Liability
State Health and Human Services
Finance Commission
P.O. Box 8206
Columbia, SC 29202-3206
(803) 253-6184

# of Recipients 264,911
Total Annual MA Payments $402.2 M
Annual State MA Payments $110.8 M

SOUTH CAROLINA



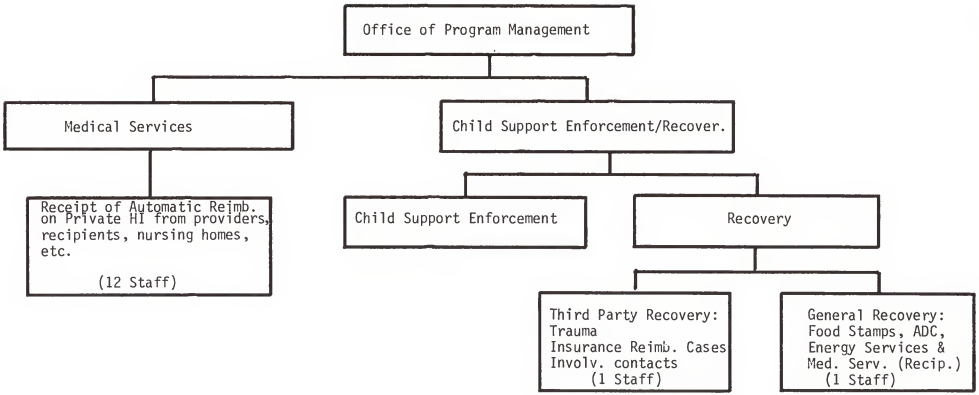
CONTACT PERSON

Dorothy J. Jones
Department of Social Services
General Recoveries & Investigations
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-5095

STATISTICS: (SFY 86)

# of Recipients	36,651
Total Annual MA Payments	$102.94 M
Annual State MA Payments	$ 33.35 M

SOUTH DAKOTA



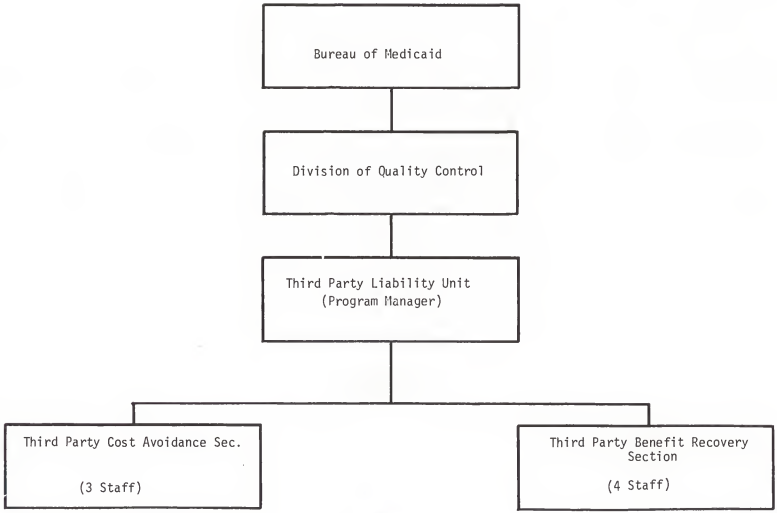
CONTACT PERSON

Lucy Hayes
TPL Program Manager
Bureau of Medicaid
729 Church Street
Nashville, Tennessee 37219
(615) 741-0207

STATISTICS: (SFY 36)

# of Recipients	394,673
Total Annual MA Payments	$719.05 M
Annual State MA Payments	$214.23 M

TENNESSEE



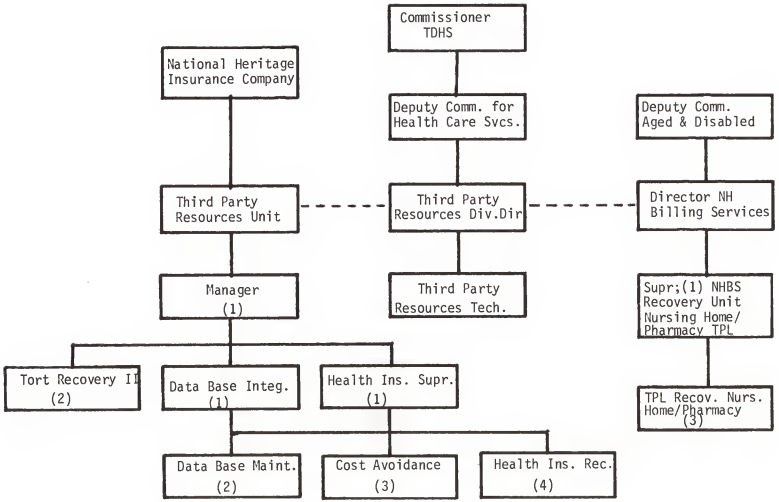
CONTACT PERSON

Terry J. Cottrell
Director-Third Party Resources
P.O. Box 2960 (611-S)
Austin, Texas 78769
(512) 338-6518

STATISTICS: (SFY 86)

# of Recipients 704 T
Total Annual MA Payments $ 1.3 B
Annual State MA Payments $797 M

TEXAS



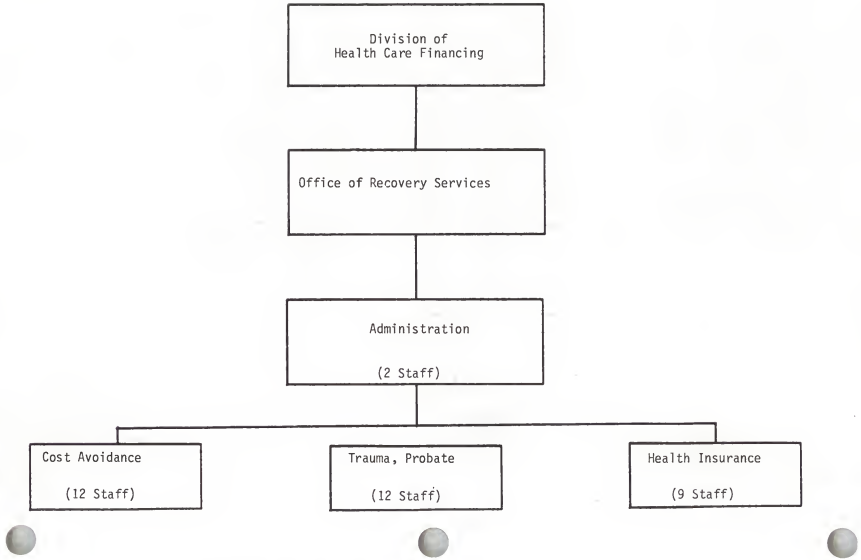
CONTACT PERSON

Pepita E. Park, Director
Bureau of Contracts and Hearings
Division of Health Care Financing
P.O. Box 16580
Salt Lake City, Utah 84116-0580
(301) 538-6405

STATISTICS: (SFY 86)

# of Recipients	51,250
Total Annual MA Payments	$179.8 M
Annual State MA Payments	$ 50 M

UTAH



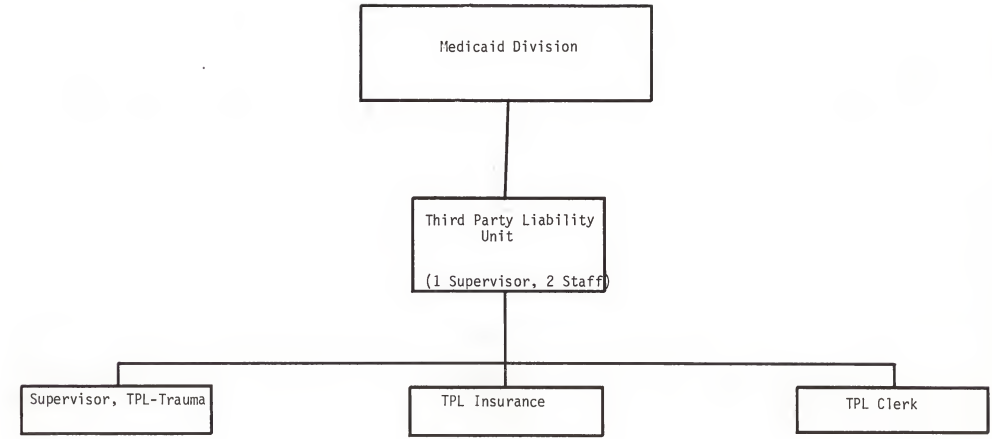
CONTACT PERSON

Bonnie Watson
Supervisor
Medicaid Recoupment
Department of Social Welfare
Medicaid Division
103 South Main Street
Waterbury, VT 05676
(802) 241-2901

STATISTICS: (SFY 86)

# of Recipients	50,012
Total Annual MA Payments	$102.3 M
Annual State MA Payments	$ 33.8 M

VERMONT



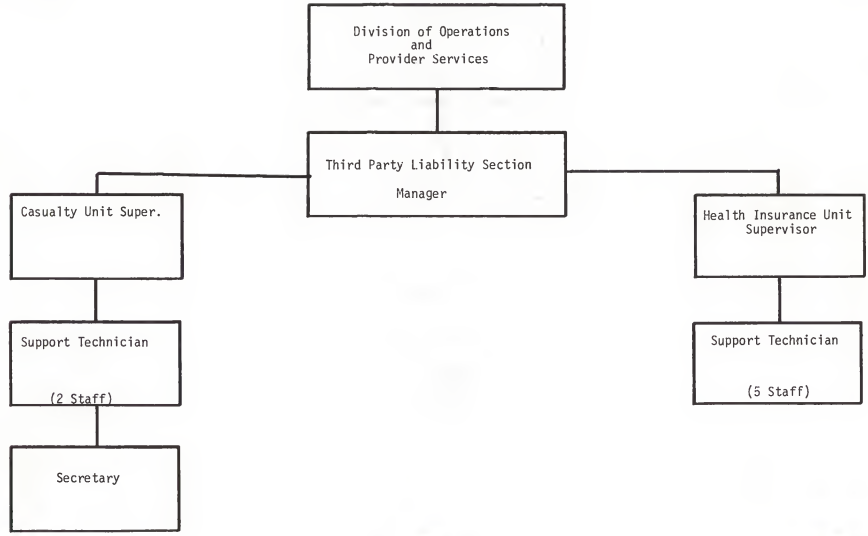
CONTACT PERSON

Ellis Abrams
TPL Section Manager
Department of Medical
Assistance Services
600 E. Broad Street
Suite 1300
Richmond, Virginia 23219
(804) 786-8434

STATISTICS: (SFY 86)

# of Recipients	314,190
Total Annual MA Payments	$647.1M
Annual State MA Payments	$301.3M

VIRGINIA



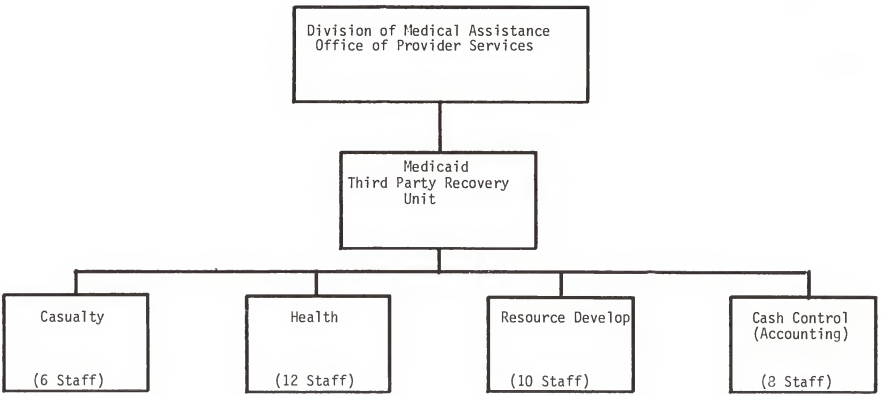
CONTACT PERSON

Dan Dowler
Chief Resource Management
Office of Provider Services
P.O. Box 9245 MS/HA11
Olympia, Washington 98504
(206) 753-2465

STATISTICS: (SFY 37)

# of Recipients	340,000
Total Annual MA Payments	$651.7 M
Annual State MA Payments	$323.6 M

WASHINGTON



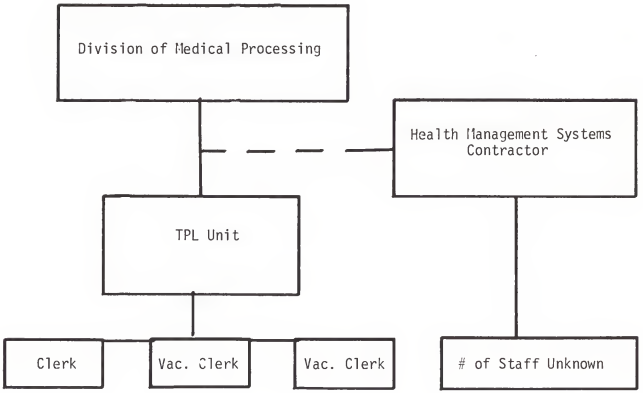
CONTACT PERSON

Jack Tamplin, Division Director
Pat Garnett, Supervisor, TPL
1900 Washington Street, East
Charleston, WV 25305
(304) 343-0560

STATISTICS: (SFY 86)

# of Recipients	211,174
Total Annual MA Payments	$207.76 M
Annual State MA Payments	$ 54.73 M

WEST VIRGINIA



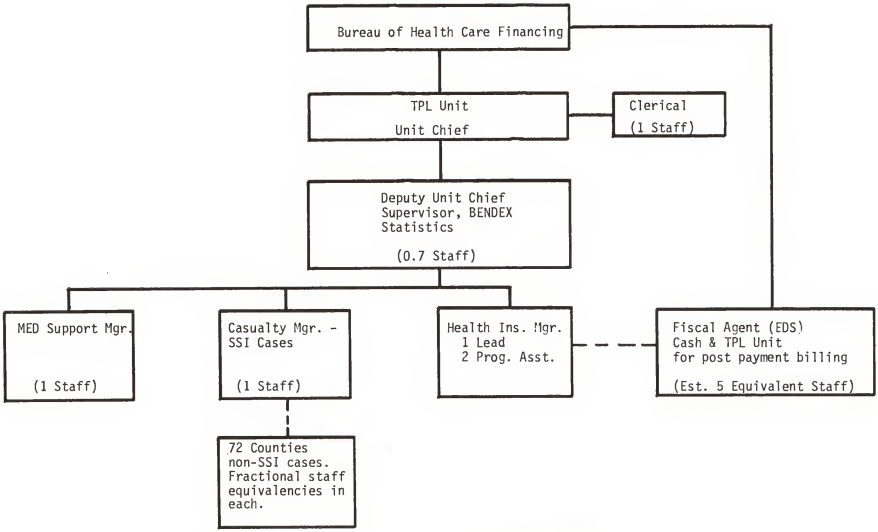
CONTACT PERSON

Jerry Buss
TPL Unit
Box 309
Madison, WI 53701
(608) 266-8747

STATISTICS: (SFY 87)

# of Recipients 400,000
Total Annual MA Payments $ 1.1 B
Annual State MA Payments $451.6 M

WISCONSIN



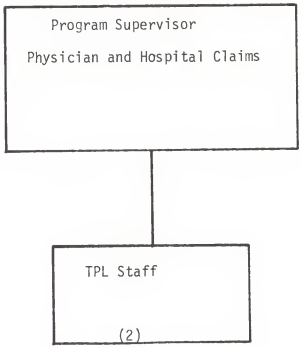
CONTACT PERSON

Linda O'Grady
Program Supervisor
Medical Assistance Services
Department of Health & Social Services
Hathaway Building
Cheyenne, WY 32002
(307) 777-7531

STATISTICS: (SFY 36)

# of Recipients	16,000
Total Annual MA Payments	$32 M
Annual State MA Payments	$16 M

WYOMING



II

SECTION II

STATE TPL FORMS

STATE TPL FORMS

ALABAMA
ARKANSAS
FLORIDA
INDIANA

ABSTRACT: A critical phase in the cost avoidance of claims and recovery of Medicaid payments is the up front identification of liable third party resources. Indeed, the ultimate success of any TPL program and the reduction of Medicaid expenditures rests on the determination of a client's medical coverage beyond Medicaid. A State's systematic approach to the identification of third party liability is a mandatory prerequisite to TPL program success. This systematic approach entails, as an initial step, the Medicaid caseworker's determination of possible TPL coverage during the eligibility or redetermination of eligibility process. To facilitate this approach, States have developed and utilized various forms to identify and document third party resources. TPL forms in this section are representative of forms provided by many States. Although not all inclusive, we believe the forms in this section represent good examples of those which are being used to capture third party resource information.

The categories of the forms are as stated below. Not each State is represented in each section.

1. Medicaid TPL Intake
2. Followup/TPL Identification
3. Followup/TPL Identification Resulting from Data Match
4. Casualty and Accident Questionnaires
5. Trauma Questionnaires

1. MEDICAID TPL INTAKE

ALABAMA MEDICAID AGENCY

This form is completed for nursing home applicants/recipients

(Point of Eligibility)

District Office Number _____

MEDICAL INSURANCE:

Do you have Medicare (Social Security Health Insurance)? ..... ☐ Yes ☐ No

What is your Medicare Number? _____

What is your Medicaid Number? _____

Do you have any other health or accident insurance policies? ..... ☐ Yes ☐ No
(This includes any accident, cancer, group, indemnity, C+ or other health insurance)

If Yes, do you, the applicant, pay the premium? ..... ☐ Yes ☐ No

If you have insurance which may cover any of your expenses, you must furnish insurance information to Alabama Medicaid Agency (DO NOT list Medicare, life or burial insurance).

_____ _____
Name Applicant/ Recipient Social Security Number

_____ _____ _____
Address Zip Phone

Health Insurance Co.
Name and Address

1. _____

_____

Policy Number _____

_____
Name of Policy Holder

Premium Amount _____

How often is premium paid? _____

2. _____

Policy Number _____

_____
Name of Policy Holder

Premium Amount _____

How often is premium paid? _____

3. _____

Policy Number _____

_____
Name of Policy Holder

Premium Amount _____

How often is premium paid? _____

4. _____

_____

Policy Number _____

Premium Amount _____

How often is premium paid? _____

5. _____

Policy Number _____

Premium Amount _____

How often is premium paid? _____

If Group Health Insurance, Employer Name and Address

_____

Group Number _____

Premium Amount _____

How often is premium paid? _____

List only family members covered by above insurance who are also eligible for Medicaid:

Name	Company and Policy Number	Medicaid Number

ARKANSAS SOCIAL SERVICES DIVISION

THIRD PARTY RESOURCE WORKSHEET

CASEHEAD _____ CASE NUMBER _____

ADDRESS _____ SOCIAL SECURITY NUMBER _____

INSTRUCTIONS

Please read the questions below and see if they apply to your client. Answers should be printed in blanks or applicable answers checked.

1. Is any case member: ☐ Blind ☐ Disabled ☐ Over 65 ☐ Chronic Kidney Disease Patient

   Are they enrolled in: ☐ Medicare A and/or B Name(s) _____

2. Is any case member covered by PRIVATE HEALTH INSURANCE? If so, complete the following: *

   Case Member Names: _____

   Company Name: _____

   Address _____

   Policy Numbers: _____
   (Group No.) (Individual No.)

3. Is any case member WORKING or a member of a LABOR UNION? If so, complete the following: *

   Name _____ Employer/Union _____

   Address of Employer/Union: _____

4. Is any case member, parent, absent parent, or spouse in the MILITARY? If so, complete the following:

   _____
   Name of Case Member Social Security Number

   Address and Branch of Service: _____

5. If there is a divorce or separation involved in this case, does the agreement or any court order require:

   ☐ Payments for Medical Care ☐ Payments for Health Insurance

   Is health insurance available through absent parent?

   Name: _____

   Insurance Company: _____

   Address: _____

   Policy Numbers: _____
   (Group No.) (Individual No.)

6. Has any case member been in an ACCIDENT requiring medical care? If so, Name: _____

   Accident Occurred: ☐ SCHOOL ☐ WORK ☐ PRIVATE PROPERTY ☐ AUTO ☐ COMMERCIAL PROPERTY ☐ OTHER

7. Do you have ADDITIONAL INFORMATION which might help identify THIRD PARTY LIABILITY?

   _____

   _____

*Use additional form for more than one policy or working case member

ARKANSAS **INSTRUCTIONS FOR**

THIRD PARTY RESOURCE WORKSHEET

PURPOSE

Often clients eligible for Medicaid have a "third party resource," such as health insurance, which could be used to pay medical bills in place of Medicaid.

This form provides some "tip-off" questions for caseworkers to assist in uncovering these third party resources and a way to record this data for use by the Medical Assistance Section.

COMPLETION

1. Use this form when any client (new or reevaluation) qualifies for Medicaid.
2. You may read or paraphrase the questions.
3. Record only affirmative answers in the blanks provided. If there is no information, leave the space blank.
4. Attach to case record.
5. Supervisor: Route only if any affirmative answers provided.

ROUTING

When completed, send to:

Medical Assistance - TPL
8th Floor
Blue Cross Blue Shield Building
Little Rock, Arkansas

If the client provides all negative responses
DO NOT return or retain the form.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
Medical Resources Documentation (SunCom 278-2495)
1317 Winewood Blvd., Bldg. 3, Rm. 405, Tallahassee, FL 32399-0700

A. PAYEE INFORMATION:

1 LAST NAME	2 FIRST NAME	3 MI	4 SEX	5 SOCIAL SECURITY NUMBER

6 CASE NUMBER	7 MEDICAID NUMBER	8 DIST.	9 CNTY.	10 UNIT	11 PROG.	12 ACTION CODE

B. CASE TYPE 13 (check type)

AFDC		PMA	
FC		Intrastate	
MAO		Interstate	
Date Public Assistance Cancelled			
/ /			

C. ABSENT PARENT INFORMATION:

14 LAST NAME	15 FIRST NAME	16 MI	17 SSN

18 RESIDENCE ADDRESS	19 MAILING ADDRESS, if different
20 EMPLOYER	21 EMPLOYER'S ADDRESS

D. INSURANCE INFORMATION:

22 CARRIER CODE	23 POLICY NUMBER	24 POLICY EFFECTIVE DATES FROM / /	TO / /

25 NAME OF INSURANCE COMPANY

26 ADDRESS OF CLAIMS OFFICE	27 CITY	28 ST	29 ZIP

30A

30 CHECK TYPE BENEFITS

___ 1. Basic Hospital Coverage	___ 7. Accident Only (non-Auto)	___ 13. Nursing Home Supplement
___ 2. Basic Medical	___ 8. Automobile	___ 14. Health Maintenance Org. (HMO)
___ 3. Basic Surgical	___ 9. Motorcycle – Passenger Accident	___ 15. Dental
___ 4. Basic Hospital/Medical/Surgical	___ 10. Specified Disease – Cancer	___ 16. CHAMPUS or CHAMPVA
___ 5. Hospital Indemnity	___ 11. Specified Disease – Heart	___ 17. Labor Union Trust/Welfare Plans
___ 6. Major Medical	___ 12. Medicare Supplement	___ 18. Continuous Care Contracts

E. TYPE OF POLICY 31 INDIVIDUAL ☐ GROUP ☐ IF "GROUP," COMPLETE FOLLOWING:

32 EMPLOYER OR GROUP MAINTAINING COVERAGE	33 GROUP NUMBER

34 GROUP ADDRESS	35 CITY	36 ST	37 ZIP

38 WHERE ARE CLAIMS FILED? Employer/Group ☐ Insurance Company ☐

F. IS ABOVE LISTED PAYEE POLICYHOLDER? 39 YES ☐ NO ☐ IF NO, COMPLETE FOLLOWING:

40 POLICYHOLDER LAST NAME	41 FIRST NAME	42 MI	43 SOCIAL SECURITY NUMBER

44 POLICYHOLDER'S ADDRESS	45 CITY	46 ST	47 ZIP

G. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

48 LAST NAME	49 FIRST	50 MI	51 RELATION CODE	52 MEMBER NO.	53 SOCIAL SECURITY NUMBER

H. COMMENTS: 54 _____

Distribution of Copies: WHITE—Medicaid Third Party
YELLOW—Caseworker

HRS Form 1293A, Sep. 88 (Replaces Jul 80 edition)
(Stock Number 5740-00A-1293-2)

55 Caseworker's Signature and Phone Number

58 Date Signed

INSTRUCTIONS FOR COMPLETING HRS FORM 1293

MEDICAL RESOURCES DOCUMENTATION FORM

1. This form must be completed by the caseworker during eligibility determination and re-determination when a client eligible for Medicaid is covered by an insurance policy covering sickness, disease or injury. If more than one policy covers an individual, a separate form must be completed for each policy. Do not complete the form if the client has Medicare coverage only; the form is not intended to place Medicare coverage information on the Third Party File. Medicare information is obtained from Bendex.

NOTE: This form is not be be completed for SSI cases placed on the eligibility file. Remember that the data supplied on the form will be printed on the recipient's Medicaid ID card and used by medical providers to bill insurance companies.

2. HRS Form 1293 is a 2-part form: Form 1293-A and Form 1293-B. The forms are identical as to information contained on the form but are used in different circumstances:

a. HRS FORM 1293-A is a 2 part NCR form which is to be used when the caseworker is documenting a particular health or accident insurance policy for the first time.

b. HRS FORM 1293 B is the computer printed turnaround document. The Medicaid Third Party Unit in Tallahassee inputs into the Third Party Liability System information received on the HRS Form 1293-A. The computer printed HRS Form 1293-B is returned to the District to be filed in the case file after verification of the information with the insurance company. Caseworkers should indicate any changes to a policy by lining out incorrect information and writing in new information in red or blue ink on the HRS Form 1293-B itself and forward it to the Medicaid Third Party Unit. After verification of the information, a new 1293-B will be returned to the District caseworker.

3. Fill out the form as completely as possible. Detailed instructions follow #7.

4. The information should be printed in red or blue ink or typed (Form 1293A).

5. Forward completed original Form 1293-A or 1293-B with corrections and updates to:

Department of Health and Rehabilitative Services
ASFMAG, Medicaid Third Party Recovery Unit
1317 Winewood Boulevard
Building 3, Room 405
Tallahassee, FL 32399-0700.

6. Caseworkers can obtain the 1293A Forms through the district supply center. Districts can order the forms, as necessary, through Jacksonville warehouse (ASCAGJ).

7. Detailed Instructions for Completing HRS Form 1293 by item number as follows:

SECTION A PAYEE INFORMATION

Items 1-3 LAST NAME, FIRST NAME, MIDDLE INITIAL - Enter name of individual to whom AFDC grant award is made or a MIC is issued (same as Item 11 on the Public Assistance Client Eligibility System (PACE); Grant Payee Name - individual to whom AFDC warrant or MIC is mailed).

Item 4 SEX - enter M for male and F for female for sex of individual in Items 1-3.

Item 5 SSN - Enter Social Security Number for the individual in Items 1-3.

Item 6 CASE NUMBER - Do not complete.

Item 7 MEDICAID NUMBER - 10 position numeric code. Enter Medicaid Number for individual in Items 1-3.

Item 8 DIST. - District Number - 2 position numeric code or 2 position numeric code with 1 position alpha code. For example - DISTRICT 1 = "01" DISTRICT 11 - "11" - DISTRICT 2A = 2A.

Item 9 CNTY - County Code. 2 position numeric code. Enter code for county of location. Same as Item 12 on the PACE. Refer to PACE manual for table of county codes.

Item 10 UNIT - For future use. Do not complete.

Item 11 PROG. - 3 position alpha-numeric code. The first position is alpha, the second and third are numeric. The alpha position identifies the category of aid, the numeric positions identify the specific program. Same as Item 34 on the PACE. Refer to PACE Manual for table of program codes.

Item 12 ACTION CODE - 1 position alpha code: A = Addition, C = Change, and D = Deletion.

A = Addition - Enter "A" when:

1. a new case or individual recipient is being added to the Recipient Eligibility File for the first time and insurance coverage was not previously reported on this form.

2. a recipient in an active case acquires insurance or new insurance for the first time.

3. a case is being reapproved after a period of more than 24 months and third party coverage is present.

C = Change - Enter "C" when:

1. original information documented is updated or corrected. Such changes should be made directly on HRS Form 1293-B, the computer turnaround document by lining out the incorrect information and writing the updated information in red or blue ink. If there are no changes to an insurance policy already documented, there is no need to take action to update the HRS Form 1293-B. Examples of changes include, but are not limited to:

   a. an individual is dropped from policy. Line out the individual dropped.

   b. an individual is added to a policy. Print the added individual's name.

NOTE - Do not line out an individual who loses Medicaid eligibility but is still covered by the policy since Medicaid will still pay claims for services provided during eligibility but received after eligibility is terminated. This form is to be used only to indicate changes to insurance policies, not to Medicaid eligibility.

2. special situation - a recipient in an active case acquires an additional insurance policy (use Form 1293-A and Action Code C in this case).

D = Deletions - USE ONLY IF ADVISED BY RECIPIENT THAT INSURANCE POLICY HAS BEEN TERMINATED AND INCLUDE THE DATE THE POLICY WAS TERMINATED. ELIGIBILITY WORKERS MUST NOT ACT ON DELETIONS OTHER THAN FORWARDING THE INFORMATION TO THE THIRD PARTY RECOVERY UNIT.

An individual is deleted from the Insurance Resource File when the individual loses Medicaid eligibility for 24 consecutive months. This information is obtained by the Medicaid Third Party Unit from reports produced from the Recipient Eligibility File.

SECTION B TO BE COMPUTER GENERATED (VIA HRS FORM 860) BY CHILD SUPPORT ENFORCEMENT (OPCSE) -
CASE TYPE - Mark appropriate box for:
AFDC - Aid to Families with Dependent Children
FC - Foster Care
MAO - Medical Assistance Only
PMA - Public Medical Assistance
Intrastate
Interstate
also enter the date Public Assistance was cancelled by using a numeric code for month, date and year. Example, September 11, 1986 would be 09/11/86.

SECTION C ABSENT PARENT INFORMATION - TO BE COMPLETED BY CHILD SUPPORT ENFORCEMENT (OPCSE).

Items 14-16 LAST NAME, FIRST NAME, MIDDLE INITIAL - Enter name of absent parent.

Item 17 SSN - Enter Social Security Number of absent parent.

Item 18 RESIDENCE ADDRESS - Enter house, apartment or lot number, street, city, state and zip code of absent parent.

Item 19 MAILING ADDRESS - Enter mailing address of absent parent only if different from residence address. If mail is sent in care of another individual, note that under Section H - Comments. Example = Section C-Item 19 is c/o Mr. John D. Doe.

Item 20 EMPLOYER - Enter name of absent parent's employer.

Item 21 EMPLOYER'S ADDRESS - Enter address of absent parent's employer.

PLEASE NOTE: COURT-ORDERED ABSENT PARENT. Determine if a court order exists which mandates that the absent parent maintain insurance coverage for his/her dependents. Indicate this in Section H - Comments. If details of policy are not known, complete Section C (boxes 14 through 21). Write comments as necessary in Section H. If the name and address of the employer are not known, complete all of Section C which is known.

If details of the policy are known, complete Section C and check the appropriate box(es) for the type of benefits available (Section D, No. 30).

SECTION D INSURANCE INFORMATION

Item 22 CARRIER CODE - 5 position numeric code. To be completed by Medicaid Third Party Unit (ASFMAG).

Item 23 POLICY NUMBER - Enter policy number, including any suffix or prefix. Should the number exceed 15 digits, enter the last 15 digits rather than the first 15 digits (i.e. digits to be dropped should be those at the beginning rather than the end of the policy number).

Item 24 POLICY EFFECTIVE DATES - Enter the date policy begins and expires by using a numeric code for day, month, and year. Example, enter 05/25/86 - 05/25/87 for a policy effective from May 25, 1986 through May 25, 1987. If the policy indicates it is "continuous until cancelled, enter "999999".

Item 25 NAME OF INSURANCE COMPANY. Enter full and complete name of Insurance Company. Abbreviating Ins. for Insurance and Co. for company is acceptable. NOTE - there are over 100 companies that begin their name with "American", 9 begin their name with "Travelers", 9 with "Hartford" etc. It is very important that you provide the full name.

Item 26 ADDRESS OF CLAIMS OFFICE - Enter the full address of the claim's office where claims for that policy would be filed. If a third party such as an adjusting firm handles all claims for that company, enter the address in items 26-29 and enter the name of the business in Section H. Example - "Claims handled by Crawford and Company at address in D26-29".

Item 30 CHECK TYPE BENEFITS. Indicate the type(s) of policy, plan, organization which provides benefits. These types do not refer to Medicaid. If you cannot determine the type of policy, attach a copy of the front page of the policy (if available) to the Form 1293 submitted to the Medicaid Third Party Unit.

1. Basic Hospial Coverage - usually includes room and board, X-rays, laboratory tests and other hospital expenses while confined as an inpatient.

2. Basic Medical Coverage - usually includes in-hospital medical services, consisting of Physician's services rendered.

3. Basic Surgical - includes coverage for surgical procedures and endoscopic procedures including pre-operative and post-operative care. Usually pays a scheduled limit for each code of operative procedure.

4. Basic Hospital/Medical/Surgical - usually includes coverage for all of the above (1, 2 and 3) in one policy.

5. Hospital Indemnity - provides daily benefits for confinement in hospital on a daily basis of not less than $10.00 per day. Benefits under this policy are usually made payable to the insured. However, Florida Statutes provide HRS with assignment rights. Therefore, HRS has full legal right to the benefits of the policy.

6. Major Medical - can be written on an individual (family) or as a group (employer) basis. It usually covers hospital, medical and surgical expenses and usually has a co-payment and deductible which are the responsibility of the insured.

7. Accident Only - covers for death, dismemberment, disability or hospital and medical care caused by an accident.

8. Automobile - three types of coverage are available. These coverages will be determined by the Third Party Unit during the verification process. Automobile policies sometimes have more than 15 digits. Because our computer file cannot hold in excess of 15 digits, please provide only the last 15 digits rather than the first 15 digits, when completing Item 23.

   *PIP of Personal Injury Protection (No-Fault insurance) provides 80% of reasonable expenses including but not limited to: medical, surgical, X-rays, dental, rehabilitative services, certain medical supplies, ambulance, hospital and nursing services, in the event of an automobile accident or while being struck as a pedestrian or bicyclist.

*Uninsured Motorist/Underinsured Motorist pays for 100% of the services above, but may pay additional benefits not paid above. Pays when a covered person is hit by an uninsured motorist (or one with very low limits of liability) after the covered person surpasses certain physical criteria.

*Medical Payments pays up to a limit of benefits chosen; usually $500.00, $1,000.00, $2,000.00, $5,000.00. Pays for necessary medical expenses and ambulance because of injury caused by an automobile accident or while struck as a pedestrian.

9. Motorcycle - Passenger Accident pays similar benefits to PIP, except that benefits are paid 100% up to a specified limit, and coverage may apply for the driver only, passenger only, or both.

10. Specified Disease - Cancer covers for cancer only, usually with a deductible. Pays for most medical services and generally accepted treatments for cancer only. These policies often do not pay for a specimen which test "benign".

11. Specified Disease - Heart covers for most conditions of heart disease. All "heart" claims will not be covered. Pays most medical services, however, few policies pay for transplants.

12. Medicare Supplement - Part A covers all eligible expenses for hospital not paid by Medicare, up to a limit. Includes deductible and coinsurance for room and board, general nursing, miscellaneous, hospital services, special care units, drugs, lab tests, X-rays, operating and recovery rooms, blood and prosthesis. Part B covers services of a physician, outpatient hospital, speech therapist, ambulance, physician administered test, medical supplies other than prescribed medication.

13. Nursing Home Supplement usually pays a stated amount per day for required skilled nursing service furnished immediately following an inpatient stay in the hospital. Coverage is offered for daily routine care, however, the policies are generally expensive.

14. Health Maintenance Organization (HMO) is a prepaid health care plan. Usually includes similar services as a major medical, but usually requires a small copayment and no deductible. May also include prescription drugs, vision and hearing, psychological and nutritional counseling.

15. Dental usually pays up to a scheduled limit for a variety of dental, peridontal and surgical procedures.

16. CHAMPUS/CHAMPVA - CHAMPUS (Civilian Health and Medical Program for Uniformed Services) covers a) family members of active duty personnel b) retirees, their spouses and unmarried children c) unremarried spouses and unmarried children of active duty or retired members d) spouses and unmarried children of reservists who are ordered to active duty 30 days or longer e) unremarried divorcees, without other health coverage, divorced after February 1, 1983, after at lest 20 years of marriage to a service member on active duty during those 20 years. CHAMPUS shares in most of the costs of care from civilian hospitals and doctors when care is not available through a military hospital or clinic. CHAMPVA (Civilian Health and Medical Program of the Veteran's Administration) shares the medical bills of families and survivors of certain veterans. Examples of CHAMPVA eligibility are: a) spouse or unmarried child of veteran with total, permanent disability resulting from service related injury b) spouse or unmarried child of veteran who died in line of duty.

17. Labor Union Trusts/Welfare Plans are individually written with benefits which have been negotiated or manuscripted for a particular labor union or employee group (such as IBM, Mobile Oil, General Electric, etc.). Generally, these policies provide greater coverage and benefits than a major medical policy.

18. Continuing Care Contracts - provides shelter, food transportation and either nursing care or personal services for residents. An entrance fee is usually charged which may be paid initially (Entry Fee) or monthly (maintenance fee). Residents may not be evicted because of their inability to pay until their prescheduled contractual termination date.

Item 30A COVERAGE TYPE CODE - Caseworkers, do not write in this space. This space is to be used by the Medicaid Third Party Unit (ASFMAG).

SECTION E TYPE OF POLICY

Items 31-38 Check appropriate box if coverage is individual or group. If coverage is maintained by a group (employer, labor union, etc.) complete Items 32 through 38 by listing the name and address of the group and enter the group number. The group number will be listed on the Certificate of Coverage.

SECTION F POLICY HOLDER INFORMATION

Complete Items 40 through 47 if the recipient is not the policy holder (the individual entered in #1-3). The policy holder is the individual in whose name the insurance policy is written. Indicate name, social security number and address of the policy holder.

SECTION G INDIVIDUALS COVERED

Begin by entering individual listed in Items 1-3, if that person is covered under the policy. Indicate last name, first name, middle initial, relationship the policyholder has to the individual covered (see Relation Codes below) member number and social security number. Note - the following Relation Codes should be entered in G-51, to denote the relationship of the policyholder to the covered individual.

1 - mother
2 - father
3 - grandparent
4 - step parent
5 - uncle/aunt
6 - legal guardian
7 - temporary guardian
8 - brother/sister
9 - other

SECTION H COMMENTS

Item 54 Provide any comments which you feel are necessary or would assist the Third Party Unit in locating and recovering from third party sources. Note - If the recipient resides in a nursing home, provide the name of the nursing home in this section. Also, if a continuous care contract is indicated in D-30, specify whether the contract is for total care or the vendor payment.

Item 55 CASEWORKER'S SIGNATURE AND PHONE NUMBER - self-explanatory.

Item 56 DATE - enter date the caseworker completes the form.

This form is completed by IV-A & IV-D workers and referred to the Medicaid Agency.

STATE OF ALABAMA
DEPARTMENT OF PENSIONS AND SECURITY

MEDICAL SUPPORT INFORMATION

County _____

CS Worker _____

DPS Case Number _____

Initial Information ____
Updated Information ____

Date _____

CLIENT	ABSENT PARENT
Name _____	Name _____
SSN _____	SSN _____
Employer _____	Employer _____
Address _____	Address _____

COURT ORDER INFORMATION (Attach copy of order)

Court Order Number _____
Is health insurance required by court order? ____
Effective Date _____
Other medical support needed _____

HEALTH INSURANCE INFORMATION

Employment Related ____
Privately Purchased ____
Other _____

Policyholder's Name _____
Insurance Company Name _____
Address _____

Type of Policy _____
Policy Number _____ Group Number _____
Beginning and Ending Dates of Coverage _____

List Medicaid-eligible persons in case covered by insurance:

FIRST	MIDDLE	LAST NAME	S.S.N.	D.O.B.

(Attach extra sheets if more than one policy)

PSD-BCS-1515

INTAKE INFORMATION

Recipient's name: _____

Recipient's Medicaid Number: _____

Recipient's Address (Street/Box): _____

City: _____

Recipient's Phone number: _____

Date of Accident: _____

Nature of Injuries: _____

_____

Other Parties Involved if Known: _____

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Tortfeasor's Name: _____

Tortfeasor's Address _____

Tortfeasor's Attorney: _____

THIS INFORMATION WAS OBTAINED THROUGH:

Name: _____

Phone Number: _____

Address: _____

City: _____

INTAKE INFORMATION TAKEN BY:

Name: _____

Date Taken: _____

2. FOLLOWUP/TPL IDENTIFICATION

HRS

TO: SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

FROM: STATE OF FLORIDA, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

SUBJECT: MEDICAL INSURANCE INFORMATION

When you applied for "SSI" your contact was with the Social Security Administration, an agency of the Federal Government. At that time, you provided information to the Federal Government so that they could determine your eligibility for "SSI".

When you were approved for "SSI" (gold colored monthly check), you became eligible for medical assistance (also known as Medicaid). Since Medicaid is administered by the State of Florida, not by the Federal Government, and we may not have had the opportunity to talk to you, it is necessary for us to obtain some information to better serve your medical needs.

The information requested at the bottom of this letter is needed to help process claims submitted to us when you receive services by hospitals, doctors, pharmacies, nursing homes, etc. It will ensure that they received correct payment for providing you medical services.

The information will NOT affect your eligibility for Medicaid but will help us in better serving you. It will be used for our department's use only and will be kept confidential.

If you have health insurance other than your Medicaid or Medicare coverage, please fill out the questionnaire as completely as possible and return this letter to us within 5 days of receipt. This questionnaire provides space for information on one health insurance policy. If you have more than one health insurance policy, please provide us with information about the second policy on a plain sheet of paper and enclose it with this questionnaire. For your convenience, fold this letter to form an envelope with the postage free return on the outside. The instructions on the back give specific directions concerning fold lines which will aid you in returning this questionnaire. Please use the gummed edge to seal the questionnaire; do not use staples or any other object for this purpose.

MEDICAL INSURANCE QUESTIONNAIRE

1. DO YOU HAVE ANY HEALTH INSURANCE (other than your Medicaid or Medicare coverage)? ___Yes ___No
2. IF YOU ANSWERED "NO" TO QUESTION 1, DO NOT COMPLETE THIS FORM AND DO NOT RETURN IT.
3. IF YOU ANSWERED "YES" TO QUESTION 1, PLEASE COMPLETE THE FOLLOWING AND RETURN.

PRINT Your Full Name (Last)_____ (First)_____ (Middle Initial) ___

Your Medicaid Number (same I.D. number that is on your green and white Medicaid I.D. card)_____

Insurance Company's Name _____

Policy Number_____ Effective Dates of Policy: from ___/___/___ to ___/___/___

What types of coverage does this policy provide? (check appropriate types)

___1. Basic Hospital	___6. Major Medical	___11. Nursing Home Supplement
___2. Basic Medical	___7. Accident Only (non-auto)	___12. HMO (non-Medicare)
___3. Basic Surgical	___8. Automobile PIP	___13. Dental
___4. Basic Hospital/Medical/Surgical	___9. Specified Disease – Cancer	___14. Champus or ChampVA
___5. Hospital Indemnity	___10. Medicare Supplement	___15. Court Ordered Ins.–Absent Parent

Weekly or monthly income while in hospital _____

Policyholder's Name and Address, if not you:

Name _____

Address _____

City _____ State_____ Zip _____

Is this policy through your employer or group (such as labor union)? ___Yes ___No If "yes", please complete the following:

Name of Employer or Group_____ Contract or Group Number _____

Address _____

City_____ State _____ Zip_____

Signature_____ Date Signed _____ Your Phone No. _____

HRS Form 1297, Mar 86 (Replaces Feb 83 edition)

3. FOLLOWUP/TPL IDENTIFICATION

RESULTING FROM DATA MATCHES

This form is computer generated from a data match with the certifying agency for ADC.

ALABAMA MEDICAID AGENCY
2500 FAIRLANE DRIVE
MONTGOMERY, ALABAMA 36130

DATE

J. MICHAEL MORSLEY
COMMISSIONER

MEDICAID #
P E S COUNTY #

RE: INSURANCE THROUGH

YOU HAVE REPORTED TO THE DEPARTMENT OF HUMAN RESOURCES THAT YOU AND/OR THE PERSONS LISTED BELOW ARE NOW OR HAVE BEEN COVERED BY HEALTH INSURANCE THROUGH THE COMPANY LISTED ABOVE. PERSONS ELIGIBLE FOR MEDICAID MAY ALSO BE COVERED BY HEALTH INSURANCE; HOWEVER, INFORMATION REGARDING THEIR INSURANCE MUST BE REPORTED TO THE MEDICAID AGENCY.

IN ORDER TO UPDATE OUR RECORDS PLEASE COMPLETE THE FOLLOWING EVEN IF YOUR INSURANCE ENDED WITHIN THE PAST 12 MONTHS.

1. LIST YOUR POLICY NUMBER_____ AND POLICYHOLDER'S NAME_____ FOR THE HEALTH INSURANCE CARRIED THROUGH THE COMPANY LISTED ABOVE.

2. ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE? YES____NO____ (DO NOT LIST MEDICARE, BURIAL, LIFE, OR CAR INSURANCE)
   IF YES, GIVE NAME OF COMPANY:_____,

   ADDRESS:_____,

   POLICY NUMBER:_____,

   POLICYHOLDER:_____.

3. TELEPHONE NUMBER WHERE YOU MAY BE REACHED BETWEEN 8:00 AM. AND 5:00 PM._____

PLEASE RETURN THIS INFORMATION, WITHIN TEN (10) DAYS, TO THE ALABAMA MEDICAID AGENCY, THIRD PARTY SECTION, 2500 FAIRLANE DR., MONTGOMERY AL 36130. FAILURE TO DO SO COULD JEOPARDIZE YOUR PRESENT OR FUTURE MEDICAID ELIGIBILITY. IF YOU HAVE QUESTIONS, YOU MAY CALL US AT 277-2710, EXTENSION 283 AND ASK FOR THE PARS CLERK.

SINCERELY,
KAY M. KEESHAN
ADMINISTRATOR, THIRD PARTY SECTION

This form is computer generated as a result of a IV-D data match.

ALABAMA MEDICAID AGENCY
2500 FAIRLANE DRIVE
MONTGOMERY ALABAMA 36130

J. MICHAEL HORSLEY
COMMISSIONER

SS # OF AP DATE

YOUR DEPENDANT (S) LISTED BELOW IS (ARE) ELIGIBLE FOR MEDICAID BENEFITS. FEDERAL REGULATIONS STIPULATE THAT MEDICAID IS THE LAST PAYOR OF MEDICAL EXPENSES INCURRED BY THOSE ELIGIBLE FOR MEDICAID, CONSEQUENTLY, THIS AGENCY HAS THE RESPONSIBILITY OF IDENTIFYING ANY RESOURCE AVAILABLE TO PAY FOR THEIR MEDICAL CARE. ONE SUCH RESOURCE IS HEALTH INSURANCE. YOU ARE URGED TO PROVIDE HEALTH COVERAGE FOR YOUR MEDICAID-ELIGIBLE DEPENDANTS AND, IF YOU DO NOT CARRY SUCH COVERAGE YOU ARE REQUESTED TO OBTAIN SUCH COVERAGE AND NOTIFY THIS OFFICE BY FURNISHING THE NAME, ADDRESS AND POLICY NUMBER OF YOUR INSURANCE, DEPENDANT (S) COVERED, THEIR MEDICAID NUMBER AND EMPLOYER INFORMATION.

TO ASSIST US IN COMPLETING YOUR DEPENDANT'S RECORDS, PLEASE COMPLETE THE FOLLOWING AND RETURN THIS LETTER TO THE ABOVE ADDRESS WITHIN TEN(10) DAYS:

NAME OF YOUR EMPLOYER:_____

ADDRESS OF YOUR EMPLOYER:_____
DO YOU CARRY HEALTH INSURANCE ON ANY OF THE BELOW-NAMED DEPENDANTS?
YES___ NO___ IF YOU HAVE ANSWERED YES, COMPLETE THE FOLLOWING:

NAME OF INSURANCE COMPANY:_____

ADDRESS:_____

POLICY NO.:_____POLICYHOLDER:_____
IS THIS INSURANCE CARRIED THROUGH YOUR EMPLOYER: YES____ NO____.
IF YOU HAVE ANY QUESTIONS, YOU MAY CALL 277-2710, THIRD PARTY SECTION, AND ADVISE YOU ARE CALLING IN REFERENCE TO LETTER 006-87.

SINCERELY,
(MRS.) KAY M. KEESHAN
ADMINISTRATOR, THIRD PARTY SECTION

MEDICAID-ELIGIBLE CHILDREN COVERED:

CHILD'S NAME	MEDICAID #	CASE NUMBER #

4. CASUALTY AND ACCIDENT QUESTIONNAIRES

INSURANCE/ACCIDENT QUESTIONNAIRE

This form is computer generated as a result of claims processing edits when trauma codes or unknown TPL resources are indicated.

ALABAMA MEDICAID AGENCY
2500 Fairlane Drive
Montgomery, AL 36130

Medicaid #
Date of Service
ICN:
Letter Code

Medicaid has paid for medical care you received on the above date. You may have health insurance or this care may have resulted from an injury. The following information is needed to determine if another source should pay your medical bill. Please answer the questions on both sides of this letter and return it to us within ten (10) days. FAILURE TO DO THIS COULD CAUSE YOU TO LOSE YOUR MEDICAID FOR UP TO ONE YEAR. Please use the enclosed stamped, addressed envelope to return this form. If you have questions, please call the Alabama Medicaid Agency and ask for the Third Party Section, (205) 277-2710.

SECTION I

Are you covered by cancer, accident, indemnity, group or individual health insurance other than Medicaid or Medicare? YES ____ NO ____

Name & Address of Insurance Company _____

_____

Policy # _____ Policyholder _____

Is this through an employer? YES ____ NO ____

Employer's name, address & telephone number: _____

_____

School name & address if school insurance: _____

_____

SECTION II

A. Were you treated on the above date because of an illness? YES ____ NO ____

If yes, state nature of illness _____

Were you treated on the above date because of an injury/accident? YES ____ NO ____
If you were treated because of an injury, check the type accident/injury:

Auto or other moving vehicle	____	Date of Injury _____
Assault (beating, rape, shooting, etc.)	____	Date of Injury _____
On the Job Injury	____	Date of Injury _____
Injury at Home	____	Date of Injury _____
Injury at School	____	Date of Injury _____
Other _____ (Specify type)	____	Date of Injury _____

B. Describe how your injury occurred _____

C. Have you retained an attorney as a result of this injury? YES ____ NO ____

Name and address of Attorney _____

Has suit been filed? YES ____ NO ____ Did you get a settlement? YES ____ NO ____

D. Did accident involve a moving vehicle? YES ____ NO ____

Was it a(n): Auto ____, Motorcycle ____, Bus ____, Other _____? (Specify)

Were you a Driver ____, Passenger ____, or Pedestrian ____?

Name and address of all drivers of vehicles _____

E. Did injury result from assault, malpractice? YES ____ NO ____

Name and address of person who injured you _____

F. Did injury occur at work? YES ____ NO ____

Name and address of your employer _____

Employer's telephone number _____

G. Did injury occur on private property (store, school, neighbor's home, relative's home, business, etc.) YES ____ NO ____

Name and address of business, school, store, or homeowner where injury occurred _____

H. If injury/accident was caused by another person or on someone else's property, did they have insurance (car, homeowner's or other liability insurance)? YES ____ NO ____

Name and address of insurance company _____

Policy Number _____ Policyholder _____

SECTION III

Telephone number where you can be reached between 8:00 and 4:30 _____

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to Alabama Medicaid Agency, and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to Alabama Medicaid Agency all claims against third parties, including tort-feasors and insurance companies, who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid. I also assign all rights in any settlement made by me and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid, whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to Alabama Medicaid Agency. I permit a copy of this authorization to be used in place of the original.

_____ _____

Recipient signature (or parent if minor) Date

IMPORTANT: CONTACT THE ACCIDENT UNIT, THIRD PARTY SECTION, ALABAMA MEDICAID AGENCY, BEFORE YOU SIGN ANY RELEASE RELATING TO ANY ACCIDENT!

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Medicaid has been notified that you may have recently been injured and received medical services which were paid by Florida Medicaid. Please answer the following questions and return this letter in the enclosed postage free envelope.

1. Is your injury the result of an accident? YES _____ NO _____

2. On what date did you have the accident? _____

3. Did your accident happen on someone else's property? (At work, at a store, at someone's house, etc.) YES _____ NO _____ If yes, NAME OF PROPERTY OWNER _____ ADDRESS _____
PHONE NO. _____

4. Do you have health or accident insurance? YES _____ NO _____ If yes,
NAME OF COMPANY _____ PHONE NO. _____
ADDRESS _____ POLICY NO. _____

5. Have you hired a lawyer, or do you plan to? YES _____ NO _____ If yes,
NAME OF LAWYER _____ PHONE NO. _____
ADDRESS _____

6. Did the accident involve a motor vehicle? YES _____ NO _____ If yes, were you the DRIVER _____ PASSENGER _____ PEDESTRIAN _____

Do you or any relative living in your house carry "No-Fault" (PIP) automobile insurance? YES _____ NO _____ If yes, NAME OF POLICYHOLDER _____
NAME OF INSURANCE COMPANY _____ PHONE NO. _____
ADDRESS _____ POLICY NO. _____

What is the name of the owner and driver of the vehicle(s)?
OWNER _____ DRIVER _____
NAME OF OWNER'S INSURANCE COMPANY _____
ADDRESS _____ POLICY NO. _____
CLAIM NO. _____ PHONE NO. _____ NAME OF DRIVER'S INSURANCE COMPANY _____ ADDRESS _____
POLICY NO. _____ CLAIM NO. _____ PHONE NO. _____

We would appreciate your enclosing a copy of any Police Incident Report which was made. Please feel free to use the back of this letter to describe or explain the incident which resulted in your injury. The information requested on this form is being collected under the authority of Chapter 409, Florida Statutes and Section 9103(a)(25) of the Social Security Act. It will be used to properly process and pay your medical bills for this accident and to determine if a third party (insurance company, another person, etc.) is legally liable to pay for your medical bills. THANK YOU FOR YOUR ASSISTANCE.

1317 WINEWOOD BLVD. • TALLAHASSEE, FL 32301

BOB MARTINEZ, GOVERNOR

Mail To: Medicaid Third Party Liability Unit
Attention: Intake
P. O. Box 6004
Indianapolis, Indiana 46206-6004

REPORT OF CASUALTY / ACCIDENT CASE

County _____ Caseworker _____ Telephone _____

FURNISH ALL APPROPRIATE INFORMATION:

SECTION I

A: Recipient Information

Eligibility Date / /

Recipient Name Last	First	Middle Initial	Medicaid #
Date of Loss (Accident / Injury)			Date Discharged from Medical Care
Nature of Injuries			

DESCRIPTION OF ACCIDENT / INJURY (Include police report, if possible) Is there a malpractice suit involved? ☐ Yes ☐ No

NAMES OF PROVIDERS TREATING THE PATIENT FOR ACCIDENT-RELATED INJURIES (INCLUDE DATES, IF KNOWN)

B: Recipient Attorney

Is the recipient represented by an Attorney? ☐ Yes ☐ No If yes, complete the next section.

Attorney's Name		Attorney's Firm's Name	
Address	City	State Zip	Phone Area Code

C: Settlement Information

Has there been a settlement? ☐ Yes ☐ No Amount: $_____ Has the case been filed in court? ☐ Yes ☐ No

Name of Court	Judge	Cause Number	Hearing Date

D: Additional Recipient Information

Were other recipients injured in the accident? ☐ Yes ☐ No
If yes, list the names and Medicaid numbers of the other involved recipients.

	NAME	MEDICAID NUMBER
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

(Continued on Reverse Side)

INDIANA

INFORMATION CONCERNING THE THIRD PARTY

COMPLETE ALL APPROPRIATE SECTIONS.

SECTION II:

Name of 3rd Party(s)

Address | City | State | Zip

A. If an attorney has been retained:

Name of Party Retaining the Attorney	Attorney's Name	Attorney's Firm's Name

Address	City	State	Zip	Phone Area Code

B. Name of Insured (if different than the 3rd party)

Address	City	State	Zip	Insured's SS#

C. Name of Insurance Company

Address	City	State	Zip	Phone Area Code

Has liability been accepted? ☐ Yes ☐ No	Date	Insurance Policy # and / or Claim #

Name of Claims Adjustor	Name of Claims Office			
Address	City	State	Zip	Phone Area Code

D. If other Third Party(s) are involved, be sure to attach additional pages using this format.

SECTION III:

A. If this was an on-the-job accident, complete the following:

Name of Employer Address	City	State	Zip	Phone Area Code

Employee's Name	SS#	Employee I.D. # and / or Clock #	Dates of Employment: From _____ to _____

B. Has the case been filed with the Industrial Board? ☐ Yes ☐ No If "yes", please complete the following:

Name of the Insured	Name of Carrier			Cause Number	Hearing Date
Address	City	State	Zip	Phone Area Code	

Insurance Policy # and / or Claim #	Name of Claims Adjustor	Name of Claims Office

Address	City	State	Zip	Phone Area Code

C. Employer Attorney

Attorney's Name	Attorney's Firm's Name

Address	City	State	Zip	Phone Area Code

ACCIDENT QUESTIONNAIRE

Dear Medicaid Recipient or Representative:

Medicaid has received a claim for services which were the result of an accident. Answer the questions on this form so that Medicaid can determine if another person or insurance company may be responsible for paying this bill.

Answer all the questions which apply to you. If a question does not apply, write "NA" (not applicable) in the space provided. If you do not have the information that is needed, please get it.

If you have any questions, please contact your Medicaid caseworker or the TPL Unit. This form must be returned to Medicaid within 14 days. No postage is required.

Sincerely,

AQ - ACCIDENT QUESTIONNAIRE

ANSWER THE QUESTIONS FOR EACH PART OF THE FORM

Part A

1 - Be sure your name, address, and Medicaid number are correct as printed. If not, please make corrections on the label at the right.

Recipient Name
Address
City, State, Zip
PCN

2 - If you have not had an accident, check here ___ ICN
DO NOT ANSWER THE REST OF THE QUESTIONS, GO TO PART C AT END.
If you have been involved in some type of accident, fill in the information requested below.

3 - Date of accident _____

4 - What type of accident was this? (Circle one)

accident was at home, school, or on someone else's property	accident was at work	accident involved a vehicle
Answer "HOME OR OTHER" questions in A below.	Answer "WORK" questions in B below.	Answer "VEHICLE" questions in C below.

HOME or OTHER:

a) If the accident happened in your home or apartment, do you have a home owner's policy? Yes_____ No_____

If yes, give name and address of insurance company. _____

b) If the accident occurred on someone else's property, where did the accident occur? (for example, at a neighbor's home, a store, a school, etc.) Give name of owner or manager, store, or school, etc. _____

Address _____

Give name and address of person's, store's or school's, insurance company, if known _____

WORK:

a) Name of employer, including plant/office/store location._____

b) Did you report the accident to your employer as having happened at work? Yes_____ No_____

c) Has a Worker's Compensation Claim been filed? Yes_____ No_____

VEHICLE:

a) Were you a driver_____, passenger_____, or pedestrian_____?

b) If you were the driver, give your vehicle insurance company name and address. _____

c) If you were a passenger or pedestrian, give driver's name, address, and social security number. _____

Give driver's insurance company's name and address

d) Where did the accident occur? Street(s) _____
City _____ County _____

Part B

1. Have you hired an attorney or has an attorney contacted you? Yes_____ No_____

   If yes, give attorney's name, address, and phone number. _____
   _____

2. Have you been contacted by an insurance company about the accident?
   Yes_____ No_____

   If yes, give policy holder's name. _____ policy #_____

   Insurance company's name and address_____ agent's name, address, and
   _____phone # _____

3. Have you received a settlement or any other money for your injuries? _____
   Yes_____ No_____

   If yes, give amount. _____

   Who issued the money to you? _____

Part C

1. Name of person completing this form. _____

2. Give phone number where you can be reached during the hours 8:00 a.m. to
   5:00 p.m. Monday through Friday. _____

3. Other comments or information regarding accident. _____
   _____

Part D

_____ _____
Signature of Person Completing Form Date

THIS FORM MUST BE RETURNED TO MEDICAID. POSTAGE IS PROVIDED.

Fold this form so the Medicaid name and address shows, seal the flap, and put in a mailbox.

5. TRAUMA QUESTIONNAIRES

TRAUMA QUESTIONNAIRE

Dear Medicaid Recipient or Representative:

Medicaid has received a claim for services to you which may have been the result of an accident. Please answer the questions on this form so that Medicaid can tell if another person or another insurance company may also be responsible for paying this bill.

Answer all of the questions which apply to you. If a question does not apply, write "NA" (not applicable) in the space provided. If you do not have the information that is needed, please get it.

If you have any questions, please contact your Medicaid caseworker or the TPL Unit. This form must be returned to Medicaid within 14 days. No postage is required.

Sincerely,

INDIANA

TQ - TRAUMA QUESTIONNAIRE 74h

ANSWER THE QUESTIONS FOR EACH PART OF THE FORM

Part A

1 - Be sure your name, address, and Medicaid number are correct as printed. If not, please make corrections on the label at the right.

Recipient Name
Address
City, State, Zip
PCN
ICN

2 - Have you been in any type of accident? (For Example on the job, automobile, a fall, or injury in a home business, etc.) Yes ____ No ____

IF YES, ANSWER THE REST OF THE QUESTIONS. IF NO, DO NOT ANSWER THE REST OF THE QUESTIONS FOLLOW THE INSTRUCTIONS IN PART C AT THE END OF THIS FORM.

3 - Date of accident _____

4 - What type of accident was this? (Circle one)

accident was at home, school, or on someone else's property	accident was at work	accident involved a vehicle
Answer "HOME or OTHER" questions below.	Answer "WORK" questions below.	Answer "VEHICLE" questions in C below.

HOME: or OTHER

a) If the accident happened in your home or apartment, do you have a home owner's policy? Yes_____ No_____

If yes, give name and address of insurance company. _____

b) If the accident occurred on someone else's property, where did the accident occur? (for example, at a neighbor's home, a store, a school, etc.) Give name of owner, manager, store, or school, etc._____

Address _____

Give name and address of person's, store's or school's, insurance company, if known _____

WORK:

a) Name of employer, including plant/office/store location._____

b) Did you report the accident to your employer as having happened at work? Yes_____ No_____

c) Has a Worker's Compensation Claim been filed: Yes_____ No_____

VEHICLE:

a) Were you a driver_____, passenger_____, or pedestrian_____?

b) If you were the driver, give your vehicle insurance company name and address. _____

c) If you were a passenger or pedestrian, give driver's name, address, and social security number._____

Give driver's insurance company's name and address

d) Where did the accident occur? Street(s) _____
City _____ County_____

TQ
Page Two

Part B

1. Have you hired an attorney or has an attorney contacted you? Yes_____ No_____

   If yes, give attorney's name, address, and phone number. _____

2. Have you been contacted by an insurance company about the accident?
   Yes_____ No_____

   If yes, give policy holder's name. _____ policy #_____

   Insurance company's name and address_____ agent's name, address, and phone #

3. Have you received a settlement or any other money for your injuries? _____
   Yes_____ No_____

   If yes, give amount. _____

   Who issued the money to you? _____

Part C

1. Name of person completing this form. _____

2. Give phone number where you can be reached during the hours 8:00 a.m. to 5:00 p.m. Monday through Friday. _____

3. Other comments or information regarding accident. _____

Part D

_____ _____
Signature of Person Completing Form Date

THIS FORM MUST BE RETURNED TO MEDICAID. POSTAGE IS PROVIDED.

Fold this form so the Medicaid name and address shows, seal the flap, and put in a mailbox.

kks/#30a11

III

SECTION III

STATE TPL TRAINING

STATE TPL TRAINING

ARKANSAS
HAWAII
KENTUCKY
PENNSYLVANIA

ABSTRACT: The overall effectiveness of the third party liability (TPL) program in reducing Medicaid losses through failure to utilize TPL resources depends on the continuing identification and use of TPL information. Essential to this goal is effective education provided to relevant State staff. Successful training procedures must include, at a minimum, (1) training caseworkers in the collection and identification of health insurance information; (2) the preparation of manuals to assist caseworkers in determining TPL coverage; (3) the training of health care providers to detect possible TPL resources.

The TPL course summaries which were reviewed in conjunction with the development of the Successful Practices Guide revealed a variety of approaches and techniques which States employ to train and assist interviewers in learning about and accessing TPL resources which may be available to Medicaid recipients.

The packages, in general, consist of an overview of TPL terms and definitions, organizational charts, helpful questions for interviewers, forms and handouts, procedures for capturing TPL information pertaining to health insurance, sample copies of TPL letters, matrices of TPL insurance payors, eligibility criteria for various TPL payors and evaluation forms by which trainees may offer an evaluative critique of their training. Some course material emphasizes identifying one or more third party payors; e.g., automobile insurance, or eligibility for Veterans Administration benefits. In addition, others went beyond the intake and interview stages to illustrate exemplary training elements on followup activity.

The State course materials summarized here were chosen for their strong emphasis on the basics and for creative innovations to caseworker education.

STATE SPECIFIC FEATURES

ARKANSAS

Training Coordinator

Wayne E. Olive, Manager
TPL Unit, Medical Assistance Section
P.O. Box 1437
Little Rock, Arkansas 72203
(501) 271-2388

Arkansas submitted a training package for all new hires on its MMIS TPL Subsystem. This training guide is used for all new hires as well as a desk reference by all other staff involved in TPL. The trainee has hands-on training on the TPL Subsystem which offers a cost-effective approach to post payment recovery activites.

The trainee is also guided through an example of the TPL resource identification process and documentation requirements. The trainee is requested to provide feedback on the training and make suggestions for changes.

HAWAII

Training Coordinator

Walter Murakami
TPL Training Specialist
Hawaii Department of Human Services
P.O. Box 339
Honolulu, Hawaii 96809
(808) 548-6503

TPL training in Hawaii is conducted yearly and includes a pre-test and a post-test. If an eligiblity worker (EW) makes a mistake in the post-test, a followup is made with the EW's supervisor to review the error with the EW and correct the mistake(s). These tests also motivate EWs to participate actively in training sessions and conscientiously learn TPL concepts and procedures. Information regarding TPL activity; i.e., cost-savings through cost-avoidance and recoveries, are disseminated periodically to provide further incentive for EWs to learn to apply TPL.

As a part of the training package, the trainee is walked through an illustration of the TPL resource identification process and documentation requirements. The trainee is also afforded an opportunity to evaluate the third party resources training.

KENTUCKY

Training Coordiantor

Laura Kovack
Supervisor, TPL Financial Services
P.O. Box 2009
Frankfort, Kentucky 40602
(502) 227-9073, Ext. 315

TPL training is given to new employees on a one to one basis. The new TPL employee training consists of complete familiarization with the TPL Desk Level Manual, computer system training, as well as individual training with a senior TPL caseworker for three to four weeks.

The TPL Desk Level Manual is organized by function, from file updating, to maintaining the recipient TPL database, through the steps required for recovery of benefit dollars. For easy reference, each section includes a sample of each item discussed, followed by the item's reference section for further detailed information. All TPL-related reports, TPL-related on-line screens, and tables of TPL codes and definitions are also included.

PENNSYLVANIA

Training Coordinator:

Judy Lininger, Chief
TPL Section
Room 111
P.O. Box 2675
Harrisburgh, PA 17105
(717) 657-4022

Pennsylvania's "TPL Resource Guide" was developed to assist the Income Maintenance Worker in identifying and recording TPL medical resources.

The first part of the guide lists several eligibility situations that are commonly encountered. For each of these situations, question areas are identified that could indicate the presence of third party medical resources (TPR). The type of potential TPR is also listed.

The second part of the guide instructs the income maintenance worker on medical resources such as Medicare, Blue Cross and Blue Shield, CHAMPUS, Private Carrier, Unlisted Carrier, Casualty and Patient Pay. Each group is described briefly. Included in this training is the necessary documentation for TPR recording, followed by the appropriate TPR codes for that group.

The "TPL Resource Guide" is used as a reference during the eligibility determination process.

IV

SECTION IV

STATE SUCCESSFUL PRACTICES

Part A - Implementation of Cost Avoidance Method of Claims Payment and Cost Avoidance Practices

Implementation of the Cost Avoidance Method of Claims Payment

ALABAMA
FLORIDA
WASHINGTON

1. Abstract - Federal regulations published on November 12, 1985, require State Medicaid agencies to use the cost avoidance method of payment in circumstances in which they have established the probable existence of third party liability at the time a claim is filed. The regulation applies to all claims processed on or after May 12, 1986, unless a waiver was requested from and approved by the the HCFA regional office. Except for services excluded through a waiver or specifically excepted by Federal regulations, States must cost avoid claims when the potential for TPL exists. The effectiveness of the cost avoidance process hinges in large part on the accuracy of the TPL data base. States' approaches in developing a TPL data base depend upon the availability of data management support, specifics contained in the data base, and cooperation from the health insurance industry. Many States have an excellent TPL data base and cost avoidance system. We have chosen to describe 3 State practices in this Guide, with particular emphasis on developing a TPL data base.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice impacts upon the entire case universe.

2.2 Savings:

There is no consistent basis on which to report and compare cost avoidance savings.

3. Ongoing, Operational, Annualized Cost

Unknown[1]	ALABAMA
Unknown[2]	FLORIDA
$80,000	WASHINGTON

[1]Costs cannot be separated from the payments to the fiscal agent.

[2]System has not been in place a sufficient time to identify on-going cost.

4. Implementation Costs/Times

Unknown[3]	6 Months	ALABAMA
$230,000	6 Months	FLORIDA
Unknown[4]	6 Months	WASHINGTON

[3]Implementation was part of the MMIS development. Costs cannot be isolated.

[4]Implementation costs cannot be determined at this time.

5. State Specific Features

ALABAMA

Alabama's cost avoidance system was developed in 1980 and is based upon a comprehensive TPL data base. The data base, hereinafter referred to as the Policy File, contains in excess of 36,000 person specific records containing health insurance data.

When the Third Party Section learns of potential health insurance, an insurance code is added to the Eligibility File. This code, when used alone, means that the insurance has not been verified. The code specifically identifies five carriers; all other carriers are identified as **"other"**. This code is used in claims processing to identify claims that may need to be filed with the insurance carrier once verification of coverage is received. After the insurance code is added, an automated letter is generated to the insurance company or employer requesting verification of coverage. At the same time, an automated suspense file is created for follow-up to the insurance company/employer if no reply is received within a specified period.

When verifications are received, they are reviewed for accuracy, batched, and a record is added to the Policy File. An additional code is added to the Eligibility File designating that coverage has been verified.

Policy File records identify specific policy information to insure that claims are cost avoided with a minimum of errors. Each record identifies such policy information as policy number, policyholder, and effective dates. Limitation codes identify policies covering only cancer or accident diagnosis as well as Medicare supplemental policies. A source code identifies how the third party information was referred; ie., by AFDC or SSI caseworker, specific data matches, court-ordered absent parent insurance, etc. It can be used as a management tool to identify the effectiveness of third party referral sources as well as a claims processing edit for IV-D related coverage.

Policy File records are very specific in terms of coverage. There are 20 coverage fields which are defined using one or more of the following: diagnosis and procedure codes, types of service, place of service and provider number format. Claims submitted to Medicaid which meet the criteria for a covered service under a policy and have not been filed with the third party are denied and returned to the provider with instructions to file with the third party.

FLORIDA

While Florida recently passed legislation providing for data matching with insurance companies, health maintenance organizations (HMOs) and preferred provider organizations (PPOs), that legislation is yet to be implemented and the majority of information on third party liability (TPL) resources comes from Medicaid recipient questionnaires completed by caseworkers during eligibility determination and redetermination interviews and from questionnaires completed by SSI recipients.

Those questionnaires provide information on the Medicaid recipient, the third party resource(s) and the departmental unit/employee submitting the document. Upon receipt, the Medicaid Third Party Unit enters the information into the Florida Medicaid Information System (FMIS). Within FMIS, the TPL information is maintained by recipient, by policy number, by coverage type and effective date. A special code identifies the TPL resources maintained by absent parents (IV-D).

Once entered into FMIS, a verification indicator is used to determine whether the TPL resource is:

1. newly entered and unverified
2. verified as valid and available for cost avoidance
3. verified as not in force or invalid information
4. trauma related with specific selective coverage.

A five digit alpha/numeric code has been assigned to each TPL carrier maintained in FMIS. Monthly, all TPL resources with verification indicators of 1, and which have been on file for less than 30 days or more than 90 days, are sorted and printed by carrier, policy number and individual covered. Various other pertinent information also appears on these printouts, which are mailed with cover letters to the appropriate carriers by the TPL Unit. The window between 30 and 90 days is excluded to allow the carriers sufficient time to respond to the first request before another one arrives.

When returned to the TPL Unit, these turnaround documents are used to change the verification indicators in FMIS to either a 2 or 3. Either of these changes results in an appropriate notice being system generated for submittal back to the caseworker. Only those TPL resources with a verification indicator of 2 are used by the claims processing system for cost avoidance. Various statistical management reports are produced from this verification process. Provided to the IV-D agency is a report of all IV-D identified coverage which lapsed or contained invalid information (verification indicator 3).

The monthly Medicaid ID cards show all verified TPL resources using the codes previously mentioned. Medicaid providers have been instructed and trained to convert those codes (carrier and coverage) to meaningful data by using billing manuals provided by the Medicaid fiscal agent. They have also been instructed that they must bill those TPL resources prior to Medicaid if a likelihood exists that the TPL resource will pay for the services provided.

During claims processing, every claim not having a third party payment indication is systematically examined for the availability of verified TPL resources for the recipient appearing on the claim. Within the claims processing system, a matrix relates the claim being processed (provider type, invoice type and procedure code) to the verified TPL resource(s) available for an action. The appropriate action of either pay, pend, deny, or pay and list is then carried out. (Pay and list is presently used only in conjunction with EPSDT, prenatal and drug claims and TPL resources maintained by IV-D absent parents.)

Claims which have been billed to and denied by the TPL resource must be submitted with a copy of the denial for proper processing by the Medicaid fiscal agent. Those claims are pended for clerical review and disposition by the TPL Unit. When necessary, the FMIS TPL resource file is updated at that time (example: cancellation of coverage).

All matrix action codes of pay and list result in the paid claim information being accumulated for monthly carrier billings. The system also processes all newly verified TPL resources against paid claims histories and extracts those paid claims which would have been cost avoided. Those monthly billings are sorted by insurance carrier and policy number and contain other pertinent information. These billings are mailed by the TPL Unit directly to the carriers with cover letters in a manner similar to the verification turnaround document process.

WASHINGTON

When TPL is probable, the submitted claim is denied and a remittance advice is sent to the provider giving him/her the name and address of the insurance carrier, the name and SSN of the insured, and the policy number.

Resubmitted claims utilize a "claim adjustment" form which facilitates tracking the original against the resubmission. When an adjustment comes in after a claim was finalized (denied, paid in full, or paid in part), the original entry in the history file is modified to reflect actions by insurors. Dollar savings are tracked from submitted claims and adjustments, based on the amount actually paid by the insurance carrier. Denied claims that are not resubmitted are assumed to be fully cost avoided at the Medicaid allowable rate.

TPL PRACTICE A-2

Validation of Reduced Nursing Home Rates Based on Services Covered by Medicare Part B

NEW YORK

1. Abstract - New York established a reduced Medicaid per diem rate for long term care facilities that reflects the average value of services covered by Part B that could be used to reduce Medicaid payments if the per diem rate bills were itemized into individual services. To check on and establish the value of the reduced rate at each facility, reports of total Part B payments made by Medicare carriers to each facility are transmitted to the State agency by tape and a computer listing of those payments is produced. The Part B payments are then allocated to Medicaid by applying the facility's percentage of Medicaid beds. The allocated amount is then evaluated against the difference between the regular and the reduced rates for the facility to determine whether an overpayment adjustment is necessary; that is, to determine if the State is being credited, on the average, for the full value of Medicare payments.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the portion of the caseload that resides in long term care facilities, and that has Medicare Part B coverage - about 4.2% of the caseload.

   2.2 Savings:

   $20 Million[1]

   [1] This figure represents the current reduction in Medicaid payments to nursing homes projected to be reimbursable through Medicare Part B.

   2.3 Other Benefits:

   In addition to getting an estimate of the value of Part B payments, this practice may also indicate when persons eligible for Part B are not enrolled. In addition, every review of nursing home reimbursement/billing practices invariably has deterrent value in other areas.

3. Ongoing, Operational, Annualized Cost

   $1,200

4. Implementation Costs/Times

   $18,000 4 Months

5. Additional Information

Postpayment audit of facilities was considered but rejected because staffing costs would have been prohibitive. Also, a post-payment audit approach would permit nursing homes to retain any overpayments discovered for almost two years before they could be recovered.

New York became aware of the likelihood that overpayments were being made as a result of a highly publicized nursing home scandal. This practice may be useful to any Medicaid agency that has reason to suspect that overpayments due to duplicative Medicare payments may be occurring. The activities involved can be performed by any agency that wishes to regardless of its claims processing environment. The only significant barrier to be overcome is working out an arrangement with the local Medicare intermediary(ies) to obtain nursing home payment data. (While most Part B payments are handled by Medicare carriers, payments to nursing homes are the responsibility of the intermediaries.)

TPL PRACTICE A-3

Advance Warning Report to Ensure Timely Enrollment in Medicare

CALIFORNIA
NEW YORK

1. Abstract - Each month the Medicaid eligibility systems in California and New York produce lists of Medicaid recipients who will reach their 65th birthdays in 3 months time. Upon receipt of the lists, county workers are responsible for communicating with each recipient and urging him/her to apply for Medicare benefits timely. Once the recipient is enrolled in Medicare that fact is recorded in the TPL file of the State's claims processing system.

While this practice operates as part of a sophisticated data processing environment, it could easily be adapted to a partially or totally manual operation as long as a date of birth tickler file can be established. Most States should have no problem generating the warning list by computer, but this is not essential.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on every recipient who is within 3 months of his or her 65th birthday.

2.2 Savings:

It is not possible to estimate the value of dollar savings directly attributed to this practice. (New York estimates that for each recipient who fails to apply for Medicare benefits, approximately $3,200 of Title XIX funds are overpaid each year.)

2.3 Other Benefits:

This practice enables the State agency to keep track of all recipients who are about to become eligible for Medicare and to assure that they are aware of their eligibility. In addition, should any recipient fail to apply, the agency will be aware of that omission and be in a position to deal with it.

Reminding recipients of their coming Medicare eligibility ninety days prior to their 65th birthdays enables them to apply on the earliest date allowed and leaves enough time for Medicare to notify them of their entitlement so that the State need not resort to retroactive billing.

3. Ongoing, Operational, Annualized Cost

Unknown[1]	CALIFORNIA
$2,300	NEW YORK

[1]Cost cannot be isolated from total eligibility system operating cost.

4. Implementation Costs/Times

Unknown[2]	Unknown[2]	CALIFORNIA
$2,900	6 Months	NEW YORK

[2]Practice in place for several years in California.

5. Additional Information

CALIFORNIA

California's eligibility system tracks the identity of the caseworker assigned to each recipient. The Medicare enrollment warning reports are, therefore, directed to individual caseworkers.

NEW YORK

New York's eligibility system tracks recipients by county of residence. In New York, Medicare enrollment warning reports are directed to county offices where they are reassigned to individual caseworkers.

SECTION IV

STATE SUCCESSFUL PRACTICES

Part B - Recovery Practices

TPL PRACTICE B-1

Probate Recoveries from Estates of Deceased Recipients

CALIFORNIA
MARYLAND
MONTANA
NEW JERSEY
OREGON

1. Abstract - Most States apply Supplemental Security Income (SSI) criteria to real property resources in determining the financial eligibility of aged Medicaid applicants/recipients. Thus, they generally exclude the value of property that is utilized as the residence of the recipient or a dependent family member from the financial computation. Several such States, however, track the value of such property through probate upon the death of the recipient and attempt to obtain repayment for the cost of services given to the recipient prior to his or her death from any proceeds accruing to the estate of the deceased through sale or transfer of the property. (See 42 CFR 433.36.)

The State Data Exchange (SDX) includes a death indicator. Also, the Social Security Administration (SSA) is in the process of developing a national Death Master File. SSA district offices will have the capability to query the file. This activity is expected to be operational beginning January 1988. States may make arrangements with SSA to receive copies of the Death Master file and updates. States interested in obtaining more information should contact:

Mike Johnson, Project Manager
SSA Death Match File
Office of Policy
Social Security Administration
Room 500, Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235
(301) 965-2863

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on every aged Medicaid recipient who owns property that has been excluded under State eligibility rules. It can also be applied to the non-aged population if institutionalized services were paid by Medicaid.

2.2 Savings:

$4.0 Million	CALIFORNIA
$1.2 Million	MARYLAND
$250,000	MONTANA
$2.6 Million	NEW JERSEY
$2.2 Million[1]	OREGON

1 Oregon estimates that the total value of its probate activities will increase to $4.3 million annually beginning July 1989.

2.3 Other Benefits:

In addition to yielding a large return in recovered program expenditures, this practice also appears to have a minor deterrent effect in discouraging applicants with property from applying for Medicaid to cover nursing home care. Many potential applicants (or their relatives) prefer not to have the State agency file probate claims against the applicant's estate and they decide not to apply for Medicaid to avoid such actions.

It is worth noting that States presently have the option under 42 CFR 433.36 to place liens against the residential property of a recipient while he or she is still alive. The States referred to here, however, believe that delaying the filing of a claim against the value of a recipient's real property until he or she is deceased avoids highly sensitive questions concerning the rights and the dignity of the individual, without materially affecting the eventual value of the State's claim or the ability of the State agency to recover Medicaid payments.

3. Ongoing Operational, Annualized Cost

$338,000	CALIFORNIA
$104,402	MARYLAND
$1,000	MONTANA
Unknown[3]	NEW JERSEY
$213,000	OREGON
Unknown[3]	PENNSYLVANIA

3 New Jersey and Pennsylvania do not track the cost of this practice apart from other recovery efforts.

4. Implementation Costs/Times

Unknown[4]	Unknown[4]	CALIFORNIA
Included in item 3	18 Months	MARYLAND
$8,000	1 Year	MONTANA
Unknown[4]	Unknown[4]	NEW JERSEY
Unknown[4]	Unknown[4]	OREGON

4 In California, New Jersey and Oregon, probate recovery activities evolved over many years, and it is not possible to estimate the cost of implementation.

State Specific Features:

CALIFORNIA

California matches the "Discontinue Due to Death Flag" from each recipient's SDX record against the State agency's vital statistics and master eligibility files to verify that a recipient is deceased and to identify client resources that may be subject to a recovery claim by the State. A computer-generated letter requesting information on the assets of the deceased recipient is then sent to next of kin identified in State files. In addition a statewide microfiche listing of all real property is reviewed as a test of the integrity of the response.

California seeks repayment of the cost of all medical services provided to the recipient after his/her 65th birthday, provided there is no surviving spouse, minor children, or blind or disabled children.

MARYLAND

In 1976 State legislation was enacted granting statutory authority to make estate claims in accordance with applicable Federal laws. Effective in 1979, the Register of Wills periodically notifies the Third Party Recovery Unit of all estates opened in Maryland. Timely notification permits the State to file estate claims.

MONTANA

State agency staff keypunch identification data for all Medicaid recipients who appear in the paid claims history file, and prepare a tape that is matched against State mortality records. "Hits" are then reviewed for possible recoveries from the estates of deceased recipients. This allows identification of both current and former Medicaid recipients who have an outstanding public assistance debt.

Montana State law allows public administrators to initiate probate actions whenever they are not started by some other party. The State agency can then file for reimbursement of previously paid medical claims.

NEW JERSEY

New Jersey concentrates its probate recovery efforts on the estates of recipients who died while residing in nursing homes. New Jersey checks SSA records for all deceased beneficiaries who are also Medicaid recipients. A form letter is sent to the estate administrator for each person so identified, and New Jersey is finding that significant recoveries are being obtained from payments made in response to these letters. All previous payments for Medicaid services made on behalf of recipients who were 65 or over with estates valued at a minimum of $3000 and Medicaid payment of at least $500 or more are the targets of New Jersey's probate recovery activity.

OREGON

Oregon files a priority claim on the estate of every deceased recipient 65 or over or upon the death of any surviving spouse, as long as there are no surviving children under 21 years of age, blind, or permanently and totally disabled (using SSI rules). The amount of the claim covers all Medicaid services received since the recipient's 65th birthday, and all State supplemental cash assistance paid to disabled recipients.

The claim is filed both with an attorney or other individual responsible for the disposition of the estate and with the court in which the estate is to be settled. The State considers the process to be virtually foolproof, in the sense that every available resource is captured with minimal effort.

TPL PRACTICE B-2

Release of Information by Providers

ALABAMA
ILLINOIS
IOWA
OHIO
PENNSYLVANIA

1. Abstract - Casualty related third party resources not known to the State may be identified through requests for medical reports and bills received by providers from attorneys, insurance companies and other parties. Some States require providers to contact the State agency before responding to such requests from insurance companies, attorneys, and other third parties. Some of these States control all such responses directly while others allow the providers to respond after referring the request to the agency for TPL follow-up.

States use this practice as a "safety net" to catch what other identification procedures miss.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe.

2.2 Savings:

$300,000	ALABAMA
$240,000	ILLINOIS
Unknown[1]	IOWA
$1.3 Million	OHIO
$2.5 Million	PENNSYLVANIA

1 Iowa cannot track specific savings from this practice, but states, qualitatively, that a substantial portion of its casualty recoveries are obtained in this way.

2.3 Other Benefits:

In addition to producing hard recoveries, this practice has a positive effect in terms of sensitizing providers, attorneys, casualty firms, and recipients to Medicaid's third party rules. When States adopt an aggressive recovery stance, all other parties involved in the process tend, over time, to cooperate voluntarily with State procedures and policies.

This practice also improves communications between providers and State agencies. What begins as a mandated restriction on release of information evolves into a two-way inquiry/response process that improves relationships and claims processing efficiency.

3. Ongoing, Operational, Annualized Cost

Minimal	ALABAMA
$72,000	ILLINOIS
$5,000	IOWA
$129,000	OHIO
Unknown[2]	PENNSYLVANIA

2 Pennsylvania is unable to isolate the cost of this practice.

4. Implementation Costs/Times

None	6 Months	ALABAMA
None	None	ILLINOIS
$1,000	8 Months	IOWA
None	None	OHIO
Minimal	6 Months	PENNSYLVANIA

5. State Specific Features:

ALABAMA

Alabama has used this practice since 1971 to identify TPL missed by trauma edits and to insure that trauma claims are not settled before the State has an opportunity to intervene. This is mandated by rules issued by the State agency.

ILLINOIS

All requests received by providers for copies of medical histories and bills of Medicaid recipients received from attorneys, insurance company representatives and other parties, are referred to the Third Party Liability Unit for response. The State agency conducts ongoing educational efforts emphasizing the providers responsibility to refer such requests to the third party unit so that potential third party resources may be identified.

IOWA

Iowa uses this practice to catch situations that are missed by trauma edits and to evaluate the effectiveness of those edits. Iowa also views this practice as an opportunity to educate providers on State procedures through training seminars. Additionally, in overcoming resistance from the Iowa Hospital Association on additional cost and reporting burdens, the State agency established a firm, no-nonsense posture with providers that improved the overall Medicaid relationship. The addition of a provider inquiry telephone line has also enabled providers to resolve a variety of other questions that arise with a minimum of effort.

OHIO

Ohio uses this practice as a primary resource identification tool. The State agency follows up on all requests for documentation with a subrogation letter to the requesting attorney or liable third party. Ohio considers this practice to be the most efficient way to utilize scarce personnel resoures to identify casualty liability. Initial resistance from attorneys was overcome by competent and timely responses by State staff, who provided the requested claims documentation rapidly to all parties who observed State procedures.

PENNSYLVANIA

Pennsylvania requires providers to send all requests for documentation to the State agency. The agency controls all responses, establishes whether a recovery situation exists, and provides claims documentation after its case is established.

TPL PRACTICE B-3

Use of Computer Generated Payment Histories in Lieu of Invoices for Billing Insurance Companies

ALABAMA
CALIFORNIA
ILLINOIS
MICHIGAN
WASHINGTON

1. Abstract - Working with the Health Insurance Association of America (HIAA) and representatives of member commercial insurance companies, the State agencies in Alabama, California, Illinois, Michigan, and Washington designed computer claims histories that are accepted as billing documents by those firms. This enabled the agencies to retire their manual processes which required hard copies of invoices photocoped from microfilm.

HIAA has agreed, in principle, to accept electroncially produced bills from all State agencies and many Blue Cross and Blue Shield (BC/BS) Plans have also done so. State agencies should contact their local HIAA representative and BC/BS management to negotiate the exact format and content of computer generated bills.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe.

2.2 Savings:

$160,000	ALABAMA
$10,000,000[1]	CALIFORNIA
$360,000[2]	ILLINOIS
Unknown[3]	MICHIGAN
$1,750,000[4]	WASHINGTON

1 California cannot estimate savings. The $10,000,000 represents revenues generated as a result of the use of this practice in FY 1986.

2 Illinois savings include averted State agency costs (45%) and averted county office costs (55%).

3 Michigan cannot estimate how much additional administrative costs would be incurred if hard copy bills had to be located and photocopied manually.

4 Washington's savings are from 6/86 to 5/87.

2.3 Other Benefits:

This practice represents an obvious efficiency for any State that utilizes an automated claims history file. In addition, while savings are recorded only in terms of directly reduced administrative costs, the real benefit of this practice is to make many more insurance billings and recoveries cost effective than would be otherwise.

3. Ongoing, Operational, Annualized Cost

$ 12,000	ALABAMA
$594,500	CALIFORNIA
$120,000[5]	ILLINOIS
$ 17,000	MICHIGAN
$ 40,000	WASHINGTON

5 Illinois costs include personnel (70%) and computer usage (30%).

4. Implementation Costs/Times

There were no directly attributable implementation costs in any of the referenced States. The effort involved in designing the reports and negotiating with insurance companies was considered a routine part of the TPL Unit's functions. In Michigan, California, Illinois, Alabama, and Washington, the programming required to generate the report was part of the MMIS development cost. (In Washington, the report was actually designed as part of an older MMIS system, and replicated in the new system that was installed in 1982.)

5. State Specific Features

ALABAMA

Alabama submits quarterly billings to insurance companies. This practice was implemented in 1980 and has consistently been a cost effective and easy method of recovery for drug claims.

CALIFORNIA

California plans to convert the automated billing report to tape for at least five large carriers, but this project is still in development.

The process of implementing computerized billing in California was more difficult that in other States because California was a pioneer in this effort. Insurance companies were not willing to accept computerized billings initially, and ultimately did so under threat of court action. This problem has now been resolved, however, and should not be a barrier for other States.

ILLINOIS

Presently, Illinois' billing reports are all produced in hard copy, with tape alternatives in planning.

MICHIGAN

Michigan presently sends tape billings to Blue Shield but plans to continue manually billing (with a paper facsimile) other insurors whose systems cannot process tape billings.

WASHINGTON

Washington is entering into discussions aimed at converting this procedure to a tape billing process for all insurors that can accept tape.

TPL PRACTICE B-4

Hospital Audits Directed at Detecting Medicaid Overpayments

FLORIDA
TEXAS
UTAH

1. Abstract - There is a common perception in many States that hospitals often receive insurance payments for the services that are paid by Medicaid, which, for a variety of reasons, do not result in refunds to the State agency. Some States conduct periodic on-site audits of hospitals to identify unreported third party health insurance payments. After sending an advance listing of the records they want to review, audit teams spend an average of a week at each hospital to pull records and search for duplicate payments. Wherever this practice exists it appears to yield an extremely high payoff.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe. In Fiscal Year 1986 in Florida, hospital providers accounted for $276 million or 27% of Florida's Medicaid expenditures.

2.2 Savings:

$1.5 Million[1]	FLORIDA
$500,000[2]	TEXAS
$1,000,000[3]	UTAH

1 Savings for 7/1/83 - 6/30/84 - $1.6 million and 7/1/84 - 6/30/85 - $1.5 million. Approximately 220 hospital providers.

2 Texas has four years of savings experience with this practice, during which the amount of documented savings decreased steadily from $750,000. The State agency believes, however, that this is due to the deterrent effect of providers anticipating a possible audit, and that if averted overpayments were counted, actual savings probably would have increased.

3 Utah's savings figure represents a limited investment of resources. The State agency believes that potential savings are enormous and limited only by the amount that can be invested in performing the audits.

2.3 Other Benefits:

In addition to recovering overpayments, this practice alerts hospital business managers of the need to reimburse Medicaid whenever insurance payments are received for claims involving Medicaid recipients. To the

degree that failure to reimburse Medicaid is a legitimate oversight, this helps to correct the omission. To the extent that such failure may not be accidental, hospitals are put on notice that Medicaid will take an aggressive position in pursuing such payments. Historically, this is known to have a considerable, but unmeasurable deterrent effect, if the agency is consistent in its pursuit. Another benefit is provider training. When requested by the provider, Florida's auditors conduct a training session for the hospital billing staff at the conclusion of the audit.

3. Ongoing, Operational, Annualized Cost

$185,400	FLORIDA
$250,000	TEXAS
$250,000[4]	UTAH

[4] Utah estimates four dollars recovered for each dollar invested.

4. Implementation Costs/Times

There are no significant implementation activities or costs associated with this practice other than the normal preparation that occurs prior to a hospital audit.

5. State Specific Features

FLORIDA

Florida's staff of 5 full time employees perform (at least once annually) an on-site audit of each Medicaid hospital provider to ensure proper provider billing and third party reporting and proper payment by the State's fiscal agent. On-site audits are conducted in one to five work days.

TEXAS

Texas now has sufficient experience with this practice that it is possible to begin to optimize the tradeoff between hard savings and their associated costs, and the deterrent savings that arise from averted overpayments. Texas is presently considering options like auditing institutions on an average of every two years to find the best mix of cost, audit savings, and voluntarily reduced overpayments.

UTAH

Prior to conducting each audit, the State agency reviews a history printout of inpatient Medicaid claims and compares payment information with hospital accounts receivable records on all claims reported, to identify possible duplicate payments or overpayments.

SECTION IV

STATE SUCCESSFUL PRACTICES

Part C - Identification of Resources

TPL PRACTICE C-1

Eligibility Matches with Blue Cross/Blue Shield (BC/BS) Plans and Other Private Insurers

CALIFORNIA
COLORADO
MICHIGAN
NEW YORK
PENNSYLVANIA
RHODE ISLAND

1. Abstract - State Medicaid files are matched against BC/BS enrollment files to verify that all covered applicants are flagged in the Medicaid files and that all flagged Medicaid recipients have valid coverage. Any conflicting information is corrected in recipient eligibility files and TPL data bases. Verified coverage information is also entered on recipient identification cards to assist providers with cost avoidance billings to BC/BS.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe.

2.2 Savings:

It is not possible to evaluate program savings that are directly attributable to this practice because States cannot determine how many "hits" obtained in this manner would have been obtained from other sources.

2.3 Other Benefits:

This practice assures that all coverage held by the insurors involved in the file match is known to the State agency with a minimum of delay. There is also an important but more subtle benefit that derives from the confidence level of the State agency, the providers, and BC/BS, that when Medicaid says a recipient has coverage, that information is almost always accurate, and coverage start and end dates are updated timely. Thus, providers react to a claim that is denied by Medicaid with BC/BS coverage indicated, knowing that payment will usually be received quickly and easily. The State agency knows that most of its denials will not result in costly follow up activities, and the carrier knows that it will receive mostly clean claims.

3. Ongoing, Operational, Annualized Cost

$ 5,000	CALIFORNIA
$ 2,600	COLORADO
$15,000	MICHIGAN
$28,000	NEW YORK
$10,500	PENNSYLVANIA
$15,000	RHODE ISLAND

4. Implementation Costs/Times

$35,000	Minimal	CALIFORNIA
$13,268	6 Months	COLORADO
$34,500	Minimal	MICHIGAN
$36,000	3 to 6 Months	NEW YORK
$28,400	6 Months	PENNSYLVANIA
$15,000	4 to 6 Months	RHODE ISLAND

5. State Specific Features

CALIFORNIA

In addition to BC/BS matches, California matches files with Cal West Insurance Company.

COLORADO

Matches with BC/BS and Prudential Insurance Company.

MICHIGAN

In addition to a monthly match, Michigan also verifies coverage with BC/BS through an on-line terminal.

NEW YORK

Conducts matches with five BC/BS plans in the State.

PENNSYLVANIA

Conducts matches with five BC/BS plans in the State.

RHODE ISLAND

Matches with BC/BS plans in the State.

In general, most insurors are willing or can be convinced to peform data matches to the extent they are able if State agencies cover the costs involved. Often, the most significant issue is which entity sends its files to the other. Usually, the carrier is unwilling to release its files, allegedly for reasons of privacy, and State agencies agree to send a tape (or equivalent medium) to the carrier (if allowed by government confidentiality requirements).

TPL PRACTICE C-2

Data Matches with Other State Agencies to Identify Health Insurance Coverage

OHIO
WASHINGTON

1. Abstract - All States offer current employees some form of health or major medical coverage, and several extend those benefits to retirees. Where State agencies that monitor these programs have a usable data base, Medicaid agencies can match against it to locate Medicaid recipients who are covered by another State program. Matches of this type are required by 42 CFR 433.152. Examples of matches for current employees' coverage and retirees' coverage are presented below.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

$900,000	OHIO
$220,000	WASHINGTON

   2.3 Other Benefits:

   Matches may identify income (pensions) which impacts on the eligibility of a recipient.

3. Ongoing, Operational, Annualized Cost

$31,000	OHIO
$1,200	WASHINGTON

4. Implementation Costs/Times

None	10 to 12 Months	OHIO
$11,300	3 Months	WASHINGTON

5. State Specific Features

   OHIO

   Ohio's public employees' retirement system offers retirees health insurance benefits for life, available from a single carrier, statewide. Once each year, Ohio matches its recipient file against the retirement systems file of enrollees. For each match, the State agency submits claims histories to the carrier.

Initially the State Retirement System resisted the data match because of privacy considerations, and because of a disagreement over which agency would pay to generate the tapes required to perform the match. These were resolved when the State Medicaid agency agreed to accept legal liability for all privacy problems, and split the cost of the match by agreeing to pay for running the match if the Retirement System paid for generation of the tape.

The Retirement System is run by a fiscal intermediary (FI) on a self-funded basis. Thus the FI was at risk for total payments and was initially not cooperative; for example, the FI refused to accept computer generated bills. The State agency maintained a tough stance, and ultimately prevailed, but the final agreement provided for payments of only 80% of the amount asked for by Medicaid. This is in line with payments made by the FI to providers; thus, the FI won the right to treat the State agency as though it were a direct-billing provider.

WASHINGTON

A match of two data files is performed every three months to determine which Medicaid recipients or absent parents of recipients are employed by the State of Washington in a capacity that provides health insurance resources for theseselves or their recipient children. A file of names, social security numbers, and birthdates of Medicaid recipients and absent parents is matched against a file of State employees who are covered by insurance. The result is a list of insured recipients and absent parents and their covered dependents.

TPL PRACTICE C-3

Identification of Accident Related Third Party Resources Through Coordination with Ambulance Service Agencies

DISTRICT OF COLUMBIA (D.C.)

1. Abstract - Use of Fire Department accident reports to identify third party resources: The D.C. Fire Department, which provides ambulance services, furnishes the TPL/Estates Section with copies of accident reports involving D.C. Medicaid recipients. These reports are submitted to the TPL Section on a weekly basis. The practice ensures the filing of claims and liens against third parties before damages can be sought or payments made to the recipient. Its greatest value is an increase in TPL collections.

2. Impact of the Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   Annual dollars recovered during FY '86 for casualty cases totaled $559,647.44.

   2.3 Other Benefits:

   Use of the Fire Department ambulance accident reports has enhanced the TPL staff's ability to obtain accident reports from the Department of Motor Vehicles (DMV) by providing time and location of each injury. The DMV reports contain the name of casualty insurance companies, policy numbers and an indicator when a claim has been filed. This allows TPL staff to seek recovery without agency/client contact.

3. Ongoing, Operational, Annualized Costs

   Minimal

4. Implementation Costs

   There are no implementation costs attributable to this practice. The State agency and the D.C. Fire Department are both components of the District Government.

5. Additional Information

   The D.C. Fire Department provides ambulance transportation to approximately 15 percent of the District's total population; 13 percent of the District's population are Medicaid Recipients. The Fire Department staff routinely verify the eligibility of each client before billing the Medicaid program; therefore, the additional effort to provide reports to the State agency is minimal. The TPL Section averages 35 accident reports per week with an average of two having potential TPL.

SECTION IV

STATE SUCCESSFUL PRACTICES

Part D - Management Practices

TPL PRACTICE D-1

Evaluation of Third Party Liability Performance at the County/Local Office Level

CALIFORNIA
NEW YORK

1. Abstract - Most effective cost avoidance systems draw heavily on the efforts of local or county welfare offices. Information about confirmed or actual insurance resources obtained by caseworkers is a major source of TPL savings. Evaluation of local office performance is one effective way to establish and provide incentive to maintain high quality and productivity in local office activities.

California and New York (both operating Medicaid under county administration) have different approaches to evaluating county office inputs. California focuses on the number of referrals and the quality of the work done in terms of how easily the results can be utilized by the State agency. New York is more result-oriented, measuring the number of known resources and the amount of savings that are attributable to the information received from each county.

Both States utilize a statewide TPL data base to evaluate and compare the performance of local districts with respect to third party activities. The performance of any specified grouping of local districts can be tracked and reported. Both systems produce computer reports that enable State staff to evaluate performance, identify weaknesses, and plan corrective actions.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe.

2.2 Savings:

There are no savings directly attributable to this practice. Evaluation is a management tool designed to improve the overall performance of county workers who are depended on to identify TPL resources and properly report the information required by the State to do effective cost avoidance.

2.3 Other Benefits:

Two primary benefits accrue from this practice. First, a sense of competition and incentive amoung county offices is created by the comparative reporting of performance statistics among the counties. Second, the State agency has a powerful management tool that enables detection of weak performers and highlights specific areas of weakness that need attention and training.

3. Ongoing, Operational, Annualized Cost

Minimal (a virtually free by-product of the TPL data base systems).

4. Implementation Costs/Times

$10,000	2 Months	CALIFORNIA
$ 5,500	6 Months	NEW YORK

5. State Specific Features

CALIFORNIA

California's system evaluates referrals received from county offices with respect to their value to the overall TPL efforts of the State agency. It counts the number of referrals received from each office, the percentage of referral forms that were received in usable (codable) form, the percentage of the Medicaid population in each county that is reflected in the referrals, and the number of forms that had to be returned for corrections or further work.

California's cost avoidance evaluation data are maintained on a microcomputer, using a commercial automated spreadsheet program. Data are stored and reported by county, with several successive quarters of data maintained on a single worksheet.

NEW YORK

The Statistical Tracking and Reporting System (STARS) data base contains 42 specific data elements related to cost avoidance and the availability of insurance. These elements are reported either directly, or in combination with other elements in mathematical formulae to derive various measures of third party liability performance.

The most widely utilized of the STARS reports ranks all local district offices' performance with respect to eight measures of detection and four measures of cost avoidance. The twelve general measures of performance presented in this and other reports are:

Recipients with known insurance (number and percent) broken out by program (Public Assistance, Medical Assistance Only, SSI, Total);

Occurrences of Insurance (number and percent) broken out by type of insuror (Medicare, Blue Cross/Blue Shield, Commercial Carriers, Total);

Amounts Cost Avoided (dollars and percent) broken out by source of payment (Medicare, Other Insurance, Individual Payment, Total).

In addition, specialized measures of performance are derived and reported for STARS and other reports as required.

TPL PRACTICE D-2

Use of Direct Recipient Mailout of Questionnaires to Detect Third Party Liability

TEXAS

1. Abstract - Federal Regulations published February 27, 1987 require State Medicaid agencies to perform systems edits to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) for purposes of determining the potential casualty related legal liability of third parties. Conducting recipient interviews on diagnosis codes where potential cases exist costs approximately $25.00 per case. Instead of the case worker obtaining the details on these cases, Texas sends out a questionnaire directly to the recipient with a postage paid return envelope. The form (8702A) also includes a WATTS line telephone number.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on all recipients involved in a trauma related injury.

   2.2 Savings:

   The practice has resulted in annual savings of $192,000.

   2.3 Other Benefits:

   The practice improves the overall efficiency of the third party liability identification process.

3. Ongoing, Operational, Annualized Costs

   $30,000 Annually

4. Implementation Costs

   Minimal

5. Additional Information

   Eighty percent of all the questionnaires are accurately completed and returned to the Texas Third Party Recovery Unit. The eligibility case worker follows up to obtain the completed questionnaire from recipients who have not returned the questionnaire to the third party recovery unit.

TPL PRACTICE D-3

Use of Hospital Admission Data to Identify Third Party Resources — **OREGON**

1. Abstract - Since hospital admission forms are a major source of leads to potential sources of third party payment, Oregon attempts to identify those leads through a review of hospital admissions data. In the practice presented below, State workers assist in the training of hospital admissions staff to identify third parties, which is a crucial function that needs to be performed as thoroughly as possible.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   $900,000

   2.3 Other Benefits:

   Income and other financial resources not previously known by the State that impact on the eligibility of the recipient are often identified.

3. Ongoing, Operational, Annualized Costs

   $186,000

4. Implementation Costs/Times

   $16,000 2 Months

5. State Specific Features

   OREGON

   State eligibility workers and specially trained TPL specialists train hospital admission staff in techniques to identify third party resources. These workers, who are also trained in case development and investigation, research each situation thoroughly and refer the results of their reviews to the Third Party Recoveries Unit. This Unit then initiates appropriate recovery actions, including the filing of liens.

   Oregon evaluated this practice during a 1983 pilot project. The project showed that some resources identified from hospital intake records might not have been found by other means for several more months. In many cases, third party resources were identified before a hospital bill was ever sent to Medicaid, thereby enabling the State to use the data for cost avoidance purposes.

TPL PRACTICE D-4

Third Party Resource Inventory Report NEW YORK

1. Abstract - The Third Party Resource Inventory Report is a comprehensive questionnaire designed to obtain information on all aspects of a local district's TPR operation. The annual report reduces the need to visit local districts to assure that they are meeting operational expectations. A complete program is being developed to store the results of each district's questionnaire. This practice may be useful in States where there are county administered programs.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   Unknown

3. Ongoing, Operational, Annualized Costs

   $18,000 (1 1/4 FTEs)

4. Implementation Costs

   None

5. Additional Information

   The report should be completed by the local Third Party Resource worker or the worker most familiar with the district's third party efforts. The district can use the completed report as a source of documentation concerning functions, workflow and duties within the TPR program.

SECTION IV

STATE SUCCESSFUL PRACTICES

Part E - Model Legislation

MODEL LEGISLATION E-1

Subrogation Rights of Medicaid Agencies

ARKANSAS
COLORADO
DISTRICT OF COLUMBIA
INDIANA
IOWA
MICHIGAN
OHIO
WASHINGTON

1. Abstract - These are basic subrogation laws that give State agencies statutory authority to place their demands ahead of (or as part of) any other claim for payment, against any insuror of a recipient of service, any tort feasor, or insuror of a tort feasor, up to the extent of the value of medical services provided to the recipient.

2. Impact of Model Legislation - These pieces of legislation enable States to enforce their status as "payor of last resort" with respect to services provided under Medicaid, by inserting themselves ahead of Medicaid recipients and other claimants, into any health insurance contract and any claim filed against a tort feasor. Subrogation laws in different States are all intended to accomplish the same general purpose, but each law has its own characteristics. These are summarized, for a number of States, on the next page:

Provision	AR	CO	DC	IN	IA	MI	OH	WA
Recipient or attorney must notify State agency of any third party claim within a reasonable time.	X	X	X		X	X	X	
Agency has right to perfect a lien.	X		X	X			X	X
Agency has right to recoup funds to cover any and all assistance provided even if unrelated to reason for settlement.	X							
Agency will pay a portion of legal fees related to third party information.	X		X	X	X	X	X	X
Providers must notify State agency of any known or likely third party information.			X		X		X	
Once notified of specific liability, insurors must reimburse the State agency regardless of payments made to others, even if insured is not a recipient but is legally responsible for one.	X		X	X	X			X

The full text of each State's existing statute (except for Colorado) follows, for the benefit of other States that may want to pursue similar legislation.

ARKANSAS Public Welfare Statute

THIRD PARTY LIABILITY FOR MEDICAL ASSISTANCE RECIPIENT

83-161. Action against third person liable for injury, disease or disability of medical assistance recipient.

A. When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury, disease or disability for which another person is liable, the Department of Human Services shall have a right to recover from such person the cost of benefits so provided. The Department may, to enforce such right, institute and prosecute legal proceedings against the third person who may be liable.

B. No action taken on behalf of the Department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the recipient, his guardian, personal representative, estate or survivors against the third person who may be liable for the injury, or shall operate to deny to the recipient the recovery for that portion of any damages not covered hereunder.

83-171.1. Action against a third person by a medical assistance recipient or a person entitled to bring action.

A. When an action or claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the Department's claim for reimbursement of the benefits provided to the recipient under the medical assistance program.

B. (Repealed.)

C. In the event of judgment or award in a suit or claim against such third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses and attorney's fees, one-third (1/3) of the remainder shall, in every case, belong to the recipient, and so much thereof as is necessary to discharge the actual amount of the Division of Social Services' claim for reimbursement shall belong to the Division, and any excess shall belong to the recipient.

83-171.2. Action against a third person by the Department and medical assistance recipient.

If an action is prosecuted both by the recipient and the Department against a third person who is liable for injury, disease, or disability of the recipient, in the event of judgment or award in a suit or claim against such third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the recipient. After payment of such expenses and attorney's fees, the court shall order that the Department receive an amount sufficient to reimburse the Department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

83-171.3. Notice of action or claim - Intervention - Consolidation

A. If either the medical assistance recipient or the Department brings an action or claim against such third person, the recipient or Department shall, within 30 days of filing the action, give to the other written notice of the action or claim by personal service or registered mail. This notice shall contain the names of the third person and the court in which the action is brought. Proof of such notice shall be filed in such action. If an action or claim is brought by either the Department or recipient, the other may, at any time before trial on the facts, become a party to the action, or shall consolidate his action or claim with the other if brought independently.

B. If the recipient, his guardian, personal representative, estate or survivors brings an action against the third person who may be liable for injury, disease or disability, notice of institution of legal proceedings and notice of settlement shall be given the secretary of the Department of Human Services. All such notices shall be given by the attorney retained to assert the recipient's claim, or by the recipient, his guardian, personal representative, estate or survivors, if no attorney is retained.

83.171.4. No judgment, award, settlements satisfied without notice to Division - Liability for misuse of funds.

No judgment, award of (or) settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease or disability, in which the Division has interest, shall be satisfied without first giving the Division notice and a reasonable opportunity to establish its interest. If, after being notified in writing of a subrogation claim and possible liability under this section, a recipient, his guardian, attorney, or personal representative disposes, without the written approval of the Division of Social Services, of the funds that are to be held for the benefit of the Division under this section, that person shall be liable to the Division for any amount that, as a result of the disposition of the funds, is not recoverable by the Division.

83-171.5. Liability of third parties to Division.

All parties who were legally liable for any or part of any medical cost of an injury, disease or disability for which the Medicaid program, established by

Arkansas Statutes, Section 83-162, has paid, or has assumed liability to pay, shall be liable to the Division of Social Services for the amount of their liability to the extent that the Division of Social Services has paid or agreed to pay.

83.171.6. Assignment to Division of rights of recovery.

The receipt of medical assistance under the Medicaid program shall constitute an automatic assignment to the Division of Social Services of the recipient's right to recovery from personal insurance or other sources or the right of recovery for personal injuries occasioned by the negligence or wrong of another to the extent of the cost of medical care services paid for by the Medicaid program.

83.171.7. Release of information to Division.

All recipients of medical assistance under the Medicaid program shall be deemed to have authorized all third parties including, but not limited to, insurance companies and providers of medical care, to release to the Division of Social Services information needed by the Division to secure or enforce its rights as assignee under Section 4 (83-171.5) of this Act.

83-171.8. Insurance policies - Prohibition against denial or reduction of benefits.

No policy of accident or illness insurance issued or renewed after July 1, 1981, shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.9. Service plan corporation contracts - Prohibition against denial or reduction of benefits.

After July 1, 1981, no service plan corporation shall deliver, issue for delivery, or renew any subscriber's contract which contains any provision denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.10. Health care providers - Prohibition against denial or reduction of benefits.

After July 1, 1981, no association authorized to do business in this State which provides or pays for any health care benefits shall issue any certificate which contains any provision denying or reducing benefits because services are rendered to a certificate holder or beneficiary who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.11. Exclusion or reduction provisions construed as inapplicable to Medicaid.

General exclusion or reduction provisions relating to benefits paid by or eligibility under governmental programs, whether State or Federal shall, not be construed to apply to the Medicaid program.

83-171.12. Billing statements.

Billing statements forwarded to recipients of medical assistance by vendors of medical care shall clearly state that reimbursement from the Medicaid program is contemplated.

COLORADO

Will provide copies of the legislation upon request.

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To authorize the District of Columbia to recoup all or part of the expenses of providing health-care assistance when the beneficiary has, or would have had, but for the government's assistance, a claim against a third party for the care and treatment the District has undertaken to provide or pay for.

Health-Care Assistance Reimbursement Act of 1984

Sec. 2. Definitions. For the purpose of this act, the term:

(1) "Beneficiary" means any individual who has received health-care assistance from the District and, if applicable, that individual's guardian, conservator, personal representative, estate, dependents, and survivors.

(2) "District" means the District of Columbia.

(3) "Health-care assistance" means health or health-related care and treatment that the District has undertaken to provide or pay for free of charge or at a discounted rate, and includes future care and treatment that the Mayor, in his or her discretion, reasonably anticipates will be provided or paid for by the District. The term "health-care assistance" includes, but shall not be limited to, medical, surgical, nursing, dental, hospital, nursing home, hospice, and home care, prostheses and medical appliances, physical and occupational therapy, counseling and psychotherapy, social work, related transportation costs, and funeral and burial expenses.

(4) "Third-party" means a third-party tortfeasor, beneficiary's insurer, or any other individual, organization, or entity that is or may be liable to a beneficiary, in tort or contract, for all or part of the care and treatment the District has undertaken to provide or pay for as health-care assistance.

Sec. 3. Right to Reimbursement Established; Subrogation and Assignment.

(a) Whenever the District provides health-care assistance to a beneficiary who has suffered an injury or illness under circumstances creating liability in a third party or under circumstances that would have created such a liability had the beneficiary, instead of the District, incurred the expense of the health-care assistance, it shall have an independent, direct cause of action against that third party for the unreimbursed value or cost of the health-care assistance provided.

(b) As soon as the District begins providing health-care assistance to a beneficiary, it shall become subrogated to any right or claim that the beneficiary has against a third party for the care and treatment it has undertaken to provide or pay for as health-care assistance. Alternatively, or in addition to the legal subrogation effected under this subsection, the Mayor may require a beneficiary to execute a written assignment of that same right or claim.

Sec. 4. Set-off

(a) Except as provided in subsection (b), whenever the District is a defendant in a proceeding brought by a beneficiary, it shall have a right to set off from a judgment against it any damages that represent compensation for the care and treatment it has undertaken to provide or pay for as health-care assistance.

(b) No set-off shall be allowed from a judgment entered against the District pursuant to any provision of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979.

Sec. 5. Enforcement of Right; Waiver

(a) In enforcing its right to reimbursement, the District may:

(1) permit the beneficiary to proceed on behalf of the District in prosecuting, in conjunction with his or her own claims, the District's claim for the unreimbursed value or cost of the health-care assistance provided;

(2) intervene or join in any proceeding brought by the beneficiary;

(3) institute and prosecute a proceeding either alone (in its own or the beneficiary's name) or in conjunction with the beneficiary; or

(4) compromise or settle and execute a release of its claim against a third party.

(b) The Mayor may waiver, in whole or in part, enforcement of the District's claim against a third party if enforcement in a particular case would not be cost effective or would result in undue hardship to the beneficiary, including any dependents or survivors of the actual recipient of health-care assistance. If waiver is based on the avoidance of undue hardship, the Mayor may in addition void the legal subrogation or assignment effected pursuant to section 3(b). In determining whether and to what extent reimbursement should be sought or awarded under this act, the Mayor or a court, respectively, shall give due consideration to the extent of the beneficiary's injuries and his or her current and future needs, including the current and future needs of any dependents or survivors of the actual recipient of health-care assistance.

(c) No proceeding prosecuted or judgment received by the District pursuant to this act shall be a bar to a beneficiary's claim or cause of action for elements of damage not covered by the District's cause of action, or shall operate to deny the beneficiary recovery of those elements of damage.

Sec. 6. Settlement Probative of Liability

Any settlement or compromise of a claim or cause of action between a beneficiary and third party for more than what in the opinion of the court is a nominal amount in light of the claims asserted shall be admissible in evidence as probative of that third party's liability to the District.

Sec. 7. Notice

(a) Any individual or institutional health-care provider that bills the District for health-care assistance furnished to a beneficiary shall provide the Mayor with written notice of any known or suspected third-party liability as soon as the health-care provider acquires knowledge of or suspects the existence of that liability. The written notice shall include the beneficiary's name and, if known, the name of the third party and a description of the circumstances allegedly creating a liability.

(b) If either the beneficiary or the Mayor separately institutes a proceeding against or settlement negotiations with a third party, the party instituting the proceeding or negotiations shall have 20 calendar days to give the other party written notice of the action by personal service or certified mail. If a court proceeding has been instituted, proof of timely notice shall be filed with the court. Whenever the Mayor separately institutes a proceeding under this act, written notice to the beneficiary shall advise him or her of the Mayor's right to reimbursement and, if the beneficiary has not proceeded to trial in another proceeding or executed a settlement agreement, his or her rights to intervene or join in the proceeding and to retain private counsel.

(c) After deducting a beneficiary's litigation costs and reasonable attorney's fees, a third party who is aware that the District might have a claim against the remainder of a judgement or settlement awarded or executed in favor of the beneficiary shall not satisfy the remainder of that judgement or settlement without first giving the Mayor both written notice of the judgment or settlement and 30 calendar days from the date notice is received to determine the appropriateness of a lien under section 8, and, if appropriate, to perfect and satisfy that lien.

(d) If a beneficiary retains private counsel, counsel shall be responsible for giving all notices required by this section.

Sec. 8. Lien

(a) Except as limited by subsections (b) and (c), the District shall have a lien, perfected in accordance with subsection (d), upon any judgement or settlement awarded or executed in favor of a beneficiary against a third party for that amount of the judgement or settlement that represents the care and treatment it has undertaken to provide or pay for as health-care assistance.

(b) If the beneficiary prosecutes a claim on behalf of the District in a proceeding or settlement negotiations and incurs a personal liability for litigation costs and attorney's fees, the Mayor shall determine in good faith what, if any, contribution to those costs and fees would be appropriate, and that contribution shall be subtracted from the amount of the lien.

(c) The beneficiary shall have the right to retain at least 1/5 of the net amount of a judgement or settlement after deducting litigation costs and a reasonable attorney's fee.

(d) To perfect a lien under this section, the Mayor, before payment of any part of a judgement or settlement is made to the beneficiary, shall:

(1) file in the Office of the Recorder of Deeds, in a docket provided for this type of lien, a written notice containing the beneficiary's name and address, the approximate date and location of the incident that caused or allegedly caused the beneficiary's injury or illness, and the name of the third party; and

(2) provide by personal service or certified mail copies of the written notice of lien together with a statement of the date of filing to the beneficiary, the third party, and, if applicable and ascertained by the Mayor, the insurer of a third-party tortfeasor.

(e) If after receiving a notice of lien under subsection (d)(2), a beneficiary, third party, or an insurer of a third-party tortfeasor disposes of funds covered by a lien perfected under this section without paying the District the amount of its lien that could have been satisfied from those funds after paying off any prior liens, that beneficiary, third party, or insurer shall, for a period of 1 year from the date the funds were improperly disposed of, be liable to the District for any amount that, because of the disposition, it is unable to recover.

Sec. 9. Rules

The Mayor may, pursuant to title 1 of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Code, sec. 1-1501 et set), issue rules to effectuate the purposes of this act, including, but not limited to, rules for:

(1) determining the unreimbursed value of health or health-related care and treatment that the District undertakes to provide directly;

(2) determining the appropriateness and amount of a District contribution under section 8(b);

(3) establishing procedures to implement the notice requirements in section 7; and

(4) facilitating the District's compliance with applicable federal regulations.

Sec. 10. Existing Rights to Reimbursement Preserved

This act shall not be construed to limit or repeal any other provision of law that invests the District with a right to reimbursement for health-care assistance provided to a beneficiary or specified class of beneficiary.

Sec. 11. Partial Retroactive Application

This act shall have full application and effect except for those pending cases in which a trail has commenced or a settlement agreement has been executed by the effective date specified in section 12.

STATE OF INDIANA'S MEDICAID STATUTE PERTAINING TO THIRD PARTY LIABILITY

IC 12-1-7-14.9(g)

"Insurer" means any insurance company, prepaid health care delivery plan, self-funded employee benefit plan, pension fund, retirement system, or similar entity that:

(1) does business in this state; and

(2) is under an obligation to make payments for medical services as a result of an injury, illness, or disease suffered by an individual.

IC 12-1-7-24.1

(a) Every applicant for or recipient of medical assistance under this chapter is considered to have authorized all insurers to release to the department all information needed by the department to secure or enforce its rights under this chapter.

(b) Every insurer shall furnish records or information pertaining to the coverage of any individual for that individual's medical costs under any individual or group policy or other obligation, or the medical benefits paid or claims made under such a policy or obligation, if the department:

(1) requests the information in writing; and
(2) certifies that the individual is:

(A) an applicant for or recipient of medical assistance; or
(B) is a person who is legally responsible for such an applicant or recipient.

However, the department may request only the records or information necessary to determine whether any insurance benefits have been or should have been claimed and paid with respect to items of medical care and services that were received by a particular individual and for which medical assistance coverage would otherwise be available.

(c) The administrator and the insurance commissioner shall establish guides for information requests under this section.

IC 12-1-7-24.2

(a) Whenever:

(1) an insurer has not discharged its obligation to make payments to an individual for medical services;

(2) that individual has (received medical assistance) from the department; and

(3) the insurer has (received notice that medical assistance has been furnished to the individual); the insurer shall make its payments directly to the department. These payments shall not exceed the amount of medical assistance paid by the department.

(b) An insurer that is put on notice of a claim by the department under subsection (a) and proceeds to pay the claim to a person or entity other than the department is not discharged from payment of the department's claim.

(c) Payment to the department by an insurer under this section discharges the insurer's obligation with respect to all further payment on the claim for the amount paid.

(d) The notice requirements of subsection (a) are satisfied if:

(1) the insurer receives from the department, by certified or registered mail, a statement of the claims paid or medical services rendered by the department, together with a claim for reimbursement; or

(2) the insurer receives a claim from a beneficiary stating that the beneficiary has applied for or has received medical assistance from the department in connection with the same claim.

An insurer that receives a claim under subdivision (2) shall notify the department of its obligation on the claim and shall pay the obligation to the provider of service, or, if the department has provided medical assistance, pay the department.

IC 12-1-7-24.4

Any clause of an insurance contract, plan, or agreement administered by an insurer is void if it limits or excludes payments to an individual who is eligible for medical assistance.

IC 12-1-7-24.6

(a) Whenever:

(1) the department pays medical expenses for or on behalf of a person who has been injured or has suffered an illness or disease as a result of the negligence or act of another person; and

(2) the injured or diseased person asserts a claim against the other person for damages resulting from the injury, illness or disease; the department

has a lien against the other person, to the extent of the amount paid by the department, on any recovery under the claim, whether by judgement, compromise, or settlement.

(b) Whenever:

(1) the department pays for medical expenses or rendered medical services on behalf of a person who has been injured or has suffered an illness or disease; and

(2) that person asserts a claim against any insurer as a result of his injury, illness, or disease; the department has a lien against the insurer, to the extent of the amount paid by the department, on any recovery from the insurer.

(c) A lien under this section is not effective unless the department takes the following actions before the party alleged to be liable has concluded a final settlement with the injured, ill, or diseased person, or his attorney or legal representative, as compensation for that person's injury, illness, or disease.

(1) Filing in the Marion County circuit court a written notice stating:

(A) notice of the eligibility of the injured, ill, or diseased person for medical assistance;

(B) the name and address of the injured, ill, or diseased person; and

(C) the name of the person, firm, or corporation alleged to be liable to the injured, ill, or diseased person.

(2) Sending to the person, firm or corporation alleged to be liable, by registered or certified mail, a copy of the notice required by subdivision (1), with a statement of the date of the filing of that notice.

(d) In addition to the requirements of subsection (c), the department shall send a copy of the notice required by subsection (c)(1) to the following persons or entities, if the appropriate names and addresses can be determined:

(1) The injured, ill, or diseased person for whom the department has paid medical expenses.

(2) Any insurance carrier that may be ultimately liable.

(3) Any attorney for the injured or diseased person.

(e) The department may, on behalf of the injured, ill, or diseased person, and to perfect a lien provided by this section, initiate and prosecute any action or proceeding against a person, firm, or corporation who may be liable to the injured, ill, or diseased person. The department may initiate such an action or proceeding only if:

(1) The injured, ill, or diseased person has not initiated legal proceedings against the person, firm, or corporation alleged to be liable; and

(2) The time remaining under the statute of limitations for the action or proceedings is six (6) months or less.

(f) Whenever the department recovers money under a lien established by this section, and that recovery is the result of a claim asserted by an injured, ill, or diseased person, the department shall pay its pro rata share of all costs and reasonably necessary expenses incurred in asserting the claim, including:

(1) deposition costs; (2) witness fees; and (3) other costs and expenses.

(g) The department shall pay attorney fees in the amount of twenty-five percent (25%) of the department's recovery under the lien, if the claim was collected without initiating legal proceedings, or thirty-three and one-third percent (33 1/3%) of the department's recovery under the lien, if the claim was collected by initiating legal proceedings.

(h) The department may waive its rights to assert a lien under this section. If the department does waive its right to a lien, it is not liable for a pro rata share of costs under subsection (f).

249A.6 Subrogation.

1. When payment is made by the department for medical care or expenses through the medical assistance program on behalf of any recipient, the department shall be subrogated, to the extent of those payments, to all monetary claims which the recipient may have against third parties as a result of the medical care or expenses received or incurred. No compromise, including but not limited to a settlement, waiver or release, of any claim to which the department is subrogated under this section shall defeat the department's right of recovery except pursuant to the written agreement of the commissioner or the commissioner's designee.

2. The department shall be given notice of monetary claims against third parties as follows:

   a. Applicants for medical assistance shall notify the department of any possible claims against third parties upon submitting the application. Recipients of medical assistance shall notify the department of any possible claims when those claims arise.

   b. Any person who provides health care services to a person receiving assistance through the medical assistance program shall notify the department whenever the person has reason to believe that third parties may be liable for payment of the costs of those health care services.

   c. Any attorney representing an applicant for or recipient of assistance on a claim to which the department is subrogated under this section shall notify the department of the claim prior to filing any claim, commencing any action or negotiating any settlement offer.

   The mailing and deposit in a United States post office or public mailbox of the notice, addressed to the department at its state or district office location, is adequate legal notice of the claim.

3. The subrogation rights of the department shall be valid and binding on an insurer or other third party only upon notice by the department or unless the insurer or third party has actual notice that the recipient is receiving medical assistance from the department and only to the extent to which such insurer or third party has not made payment to the recipient or an assignee of the recipient prior to such notice. Payment of benefits by an insurer or third party pursuant to the subrogation rights hereunder shall discharge such insurer or third party from liability to the recipient or the recipient's assignee to the extent of such payment to the department.

4. In the event a recipient of assistance through the medical assistance program incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department is subrogated under this section, the amount which the department is entitled to recover under subsection 1, or any lesser amount which the department may agree to accept in compromise of its claim, shall be reduced by an amount which bears the same relationship to the total amount of attorney fees and court costs actually paid by the recipient as the amount actually recovered by the department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the recipient. An attorney acting on behalf of a recipient of medical assistance for the purpose of enforcing a claim to which the department is subrogated shall not collect from the recipient any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this section.

5. For purposes of this section, the term "third party" includes any individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for or recipient of assistance under the medical assistance program.

498-75.2(249A) Medical resources. (Effective January 1, 1984)

Medical resources include health and accident insurance, eligibility for care through Veterans Administration, Specialized Child Health Services, Title XVIII of the Social Security Act (Medicare) and other resources for meeting the cost of medical care which may be available to the recipient. Such resources must be used when reasonably available.

When a medical resource may be obtained by filing a claim or an application, and cooperating in the processing of that claim or application, that resource shall be considered to be reasonably available, unless good cause for failure to obtain that resource is determined to exist.

Payment will be approved only for those services or that part of the cost of a given service for which no medical resources exist. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete form MA-2120-0, Request for Information Re Private Health Insurance Coverage and Other Medical Benefits, and return such to the local office of the Department of Human Services. Persons eligible for Part B of the Medicare program shall make assignment to the department on form MA-21-6-6, Statement Regarding Assignment of Claims--Part B, Medicare.

(1) The recipient, or one acting on the recipient's behalf, shall be a claim, or submit an application, for any reasonably available medical resource, and shall also cooperate in the processing of the claim or application. Failure to

do so, without good cause, shall result in the termination of medical assistance benefits. The medical assistance benefits of a minor or a legally incompetent adult recipient shall not be terminated for failure to cooperate in reporting medical resources.

(3) Good cause for failure to cooperate in the filing or processing of a claim or application, shall be considered to exist when the recipient, or one acting on behalf of a minor, or of a legally incompetent adult recipient, is physically or mentally incapable of cooperation. Good cause shall be considered to exist, when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the recipient for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult recipient, for whom medical resources are being sought.

(4) The determination of good cause shall be made by the Utilization Review Section of the Bureau of Medical Services. This determination shall be based on information and evidence provided by the recipient, or by one acting on the recipient's behalf.

75.4(2)

The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any medical assistance recipient. If a recipient of the medical assistance program incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department is subrogated, the court costs and reasonable attorney fees shall first be deducted from the judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the recipient. From the remaining balance, the claim of the department shall be paid. Any amount remaining shall be paid to the recipient. The department will provide computer generated documents or claim forms describing the services for which it has paid upon request of any affected recipient or such recipient's attorney. Such documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3)

In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the recipient or one acting on the recipient's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult recipient shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until such time as an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. Such incurred medical expense shall not be paid by the medical assistance program.

a. The applicant, or recipient, or one acting on the applicant or recipient's behalf, shall provide information and verification as required to establish the availability of medical or third party resources.

b. At time of application, the applicant or one acting on the applicant's behalf, shall report the existence of any potential medical resource. The applicant, or one acting on the applicant's behalf, shall promptly report any changes in medical resources that occur during the application process.

c. The recipient, or one acting on the recipient's behalf, shall timely report to the department, both the existence of any potential medical resources, or any changes in existing medical resources.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes or ends.

(2) The date that eligibility begins for care through Veterans Administration, Specialized Child Health Services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the recipient, or one acting on the recipient's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by medical assistance.

(4) The date the recipient, or one acting on the recipient's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by medical assistance.

(5) The date that the recipient, or one acting on the recipient's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by medical assistance.

The recipient may report the change in person, by telephone, by mail or by using the Ten Day Report of Change, form PA-4106-0, which is mailed with the Aid to Dependent Assistance warrants.

d. The recipient, or one acting on the recipient's behalf, shall complete the Recipient Inquiry, form MA-4047-0, when the department has reason to believe that the recipient has received an accident related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of medical assistance benefits.

e. In those instances where the recovery rights of the department are adversely affected by the actions of a parent or payee, acting on the behalf of a minor, or legally incompetent adult recipient, the medical assistance benefits of the parent or payee shall be terminated. In those instances where a parent or payee fails to cooperate in completing or returning the Recipient Inquiry,

form MA-4047-0, or fails to give complete and accurate information concerning the accident related injuries of a minor or legally incompetent adult recipient, the medical assistance benefits of the parent or payee shall be terminated.

f. The recipient, or one acting on the recipient's behalf, shall refund to the department any settlement or payment received, that is intended to cover any medical expenses that would otherwise be paid by medical assistance. Failure of the recipient to do so shall result in the termination of medical assistance benefits. In those instances where a parent or payee, acting on the behalf of a minor, or of a legally incompetent adult recipient, fails to refund such a settlement overpayment to the department, the medical assistance benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Inpatient Hospital Claim, form XIX HOSP-1, the Outpatient Hospital Claim, form XIX HOSP-2, or on the Health Insurance Claim, form HCFA 1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a recipient, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for or a past or present recipient of medical assistance on a claim to which the department is subrogated under this section shall notify the department of the claim of which the attorney has actual knowledge, prior to filing a claim, commencing an action or negotiating a settlement offer. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or district office location, is adequate legal notice of the claim.

75.4(5) Subrogation rights of the department.

a. The subrogation rights of the department are valid and binding on an attorney, insurer, or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the recipient is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the recipient or an assignee of the recipient prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's

involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code 249.A.6. Payment of benefits by an insurer or third party pursuant to the subrogation rights of this section discharges the attorney, insurer or other third party from liability to the recipient or the recipient's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing an applicant for or recipient of medical assistance on a claim to which the department is subrogated under this section, the department shall issue notice to that attorney of the department's subrogation rights by mailing the Attorney Letter, form MA-4050-0, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a recipient's medical expenses, the department shall issue notice to the insurer of the department's subrogation rights by mailing the Notice of Subrogation, form MA-4053-0, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6)

For purposes of this rule the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for or a past or present recipient of assistance under the medical assistance program.

This rule is intended to implement section 249A.6, The Code.

MICHIGAN STATE SUBROGATION STATUTE

400.106 "Medically indigent individual" and "medical institution" defined.

(1) A medically indigent individual is defined as:

(a) An individual receiving aid to dependent children, or an individual eligible for aid to dependent children, or children 18 to 21 eligibile for aid to dependent children except for their age, and the adult caretakers living with those children, or a child up to 21 years of age although not receiving aid to dependent children who meets the means test under the Aid to Dependent Children program, or an individual receiving or eligible to receive Supplemental Security Income under title XVI of the Social Security Act, 42 U.S.C. 1381 to 1385, or state supplementation thereunder subject to limitations imposed by the director pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k, or

(b) An individual meeting all of the following conditions:

(i) The individual has made application in the manner prescribed by the state department.

(ii) The individual's need for the type of medical assistance available under this Act for which application has been made and the need professionally established and payment for it is not available throught the legal obligation of a contractor, public or private, to pay or provide for care without regard to the income or resources of the patient. The department shall be subrogated to any right of recovery which a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the department for the care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an injury or disability for which the patient is entitled to medical care or reimbursement for the cost of medical care ... or under any other policy of insurance providing medical or hospital benefits, or both, for the patient unless the patient's entitlement to that medical care or reimbursement is at issue. If a payment is made, the department, to enforce its subrogation right, may (i) intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, the person's guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased,

or disabled patient, or (ii) institute and prosecute legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, in State or federal court, either alone or in conjunction with the injured, diseased, or disabled person, the person's guardian, personal representative, State, dependents, or survivors. The department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, the person's guardian, personal representative, estate, dependents, or survivors. ...(T)he department, in enforcing its subrogation right, shall not satisfy a judgment against the third person's property which is exempt from levy and sale. The injured, diseased, or disabled person may proceed in his or her own name, collecting the costs without the necessity of joining the department or the State as a named party. The injured, diseased, or disabled person shall notify the Department of the action of proceeding entered into upon commencement of the action or proceeding. An action taken by the State or the Department in connection with the right of recovery afforded by this section shall not operate to deny the injured, diseased, or disabled person any part of the recovery beyond the costs expended on the person's behalf by the Department. The costs of legal action initiated by the State shall be paid by the State. A payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the patient is entitled to medical care or the cost thereof . . .; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under Act No. 317 of the Public Acts of 1969, as amended, entitlement thereto has not been finally determined, and an arrangement satisfactory to the State Department has been made for reimbursement if the claim under Act No. 317 of the Public Acts of 1969, as amended, is finally sustained.

(iii) The individual has an annual income which is below or, because of medical expenses, falls below the proctected basic maintenance level. The protected basic maintenance level for aid to dependent children related families shall be 100 percent of the basic aid to dependent children standard of need. The protected basic maintenance level for related individuals under title XVI of the Social Security Act, 42, U.S.C. 1381 to 1385, shall be established by the State Department in an amount not less than the Supplemental Security Income supplementation standard. These levels shall recognize regional variations.

(iv) The individual, if an aid to dependent children related individual and living alone, has liquid or marketable assets of not more than $1,500.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than $2,000.00 in value, the Department shall establish comparable liquid or marketable asset amounts for larger

family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead, clothing and household effects, $1,000.00 of cash surrender value of life insurance, except if the health of the insured is such as to make continuance of the insurance desirable, the entire cash surrender value of life insurance is to be excluded from consideration, up to the maximums provided or allowed by federal regulations and in accordance with the rules of the State department, the fair market value of tangible personal property used in earning income, and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program of the Social Security Act, 42 U.S.C. 1381 to 1385, the appropriate resource levels and property exemptions specified therein shall be used.

(v) The individual is not an inmate of a public institution except as a patient in a medical institution.

(vi) The individual meets the eligibility standards for Supplemental Security Income under title XVI of the Social Security Act, 42 U.S.C 1381 to 1385, or State Supplementation under the act, subject to limitations imposed by the director pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k, or for aid to dependent children, except for income or income and resources, or a child 18 to 21 and his adult caretaker who would be eligible for aid to dependent children except for age, income, or income and resources, or he is a child under 21 from a family whose income is below the basic maintenance level.

(2) As used in this Act, "medical institution" means a state licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit thereof certified as meeting established standards for a nursing home or hospital in accordance with the laws and rules of this state.

OHIO REVISED CODE SECTIONS 5101.58 and 5101.59

5101.58 Right of subrogation

The acceptance of aid ... gives a right of subrogation to the Department of Public Welfare and the Department of Welfare of any county against the liability of a third party for the cost of medical services and care arising out of injury, disease, or disability of the recipient. When an action or claim is brought against a third party by a recipient of aid ..., the entire amount of any settlement or compromise of the action or claim, or any court award or judgment is subject to the subrogation right of the Department of Public Welfare or the Department of Welfare of any county. The Departments' subrogation claim shall not exceed the amount of medical expenses paid by the Departments on behalf of the recipient. Any settlement, compromise, judgment, or award that excludes the cost of medical services or care shall not preclude the Departments from enforcing their rights under this section.

Prior to initiating any recovery action, the recipient or his representative shall disclose the identity of any third party against whom the recipient has or may have a right of recovery. Disclosure shall be made to the Department of Public Welfare when medical expenses have been paid . . .. Disclosure shall be made to both the Department of Public Welfare and the appropriate County Welfare Department when medical expenses have been paid. No settlement, compromise, judgment, or award or any recovery in any action or claim by a recipient where the Departments have a right of subrogation shall be made final without first giving the appropriate Departments notice and a reasonable opportunity to perfect their rights of subrogation. If the Departments are not given appropriate notice, the recipient is liable to reimburse the Departments for the recovery received to the extent of medical payments made by the Departments. The Departments shall be permitted to enforce their subrogation rights against the third party even though they accepted prior payments in discharge of their rights under this section if, at the time the Departments received such payments, they were not aware that additional medical expenses had been incurred but had not yet been paid by the Departments. The third party becomes liable to the Department of Public Welfare or County Department of Welfare as soon as the third party is notified in writing of the valid claims for subrogation under this section.

Subrogation does not apply to that portion of any judgment, award, settlement, or compromise of a claim, to the extent of attorney's fees, costs, or other expenses incurred by a recipient in securing the judgement, award, settlement, or compromise, or to the extent of medical, surgical, and hospital expenses paid by such recipient from his own resources. Attorney fees and costs of other expenses in securing any recovery shall not be assessed against any subrogated claims of the Departments.

To enforce their subrogation rights, the Departments may do any of the following:

(A) Intervene or join in any action or proceeding brought by the recipient or on his behalf against any third party who may be liable for the cost of medical services and care arising out of the recipient's injury, disease, or disability;

(B) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical services and care arising out of the recipient's injury, disease, or disability.

WASHINGTON STATUTE

RCW 74.09.180

The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: Provided, however, that the Secretary of the Department of Social and Health Services may, in his discretion, furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the Department of Social and Health Services shall thereby be subrogated to the recipient's rights against the recovery had from any tort feasor and/or his or her insurer and shall have a lien thereupon to the extent of the value of the assistance furnished by the Department of Social and Health Services: Provided further, That to the end of securing reimbursement of any assistance furnished to such a recipient, the Department of Social and Health services may, as a nonexclusive legal remedy, assert and enforce a lien upon any claim, right of action, settlement proceeds, and/or money, including any claim for benefits arising from an insurance program, to which such recipient is entitled (a) against any tort feasor and/or insurer of such tort feasor, or (b) any contract of insurance, purchased by the recipient or any other person, providing coverage to such recipient for said injuries, any illness, dental costs, costs incident to birth, or any other coverage for purposes of or costs for which the department provides assistance or meets all or part of the cost of care to a vendor, to the extent of the assistance furnished by said department to the recipient. If a recovery shall be made and the subrogation or lien is satisfied either in full or in part as a result of an independent action initiatied by or on behalf of a recipient to recover the personal injuries against any tort feasor or insurer, then and in that event the amount repaid to the State of Washington as a result of said action, whether concluded by entry of a judgment or compromise and settlement, shall bear its proportionate share of attorney's fees and costs incurred by the injured recipient or his widow, children, or dependents, as the case may be, to the extent that such attorney's fees and costs are approved by the court in which the action is initiated, and upon notice to the department which shall have the right to be heard on the matter.

Subrogation rights created by this section may be enforced separately or jointly by the Department of Public Welfare and the County Welfare Department.

The right of subrogation given to the Department under this section does not include rights to support from any other person assigned to the State . . ., but includes payments made by a third party under contract with a person having a duty to support.

MODEL LEGISLATION E-2

Co-endorsement of Insurance Checks by Providers **WASHINGTON**

1. Abstract - This law requires that all checks from health insurance companies regulated under State law be made payable to and endorsed by both the insured and the provider of service.

2. Impact of Model Legislation - The purpose of this legislation is to prevent individuals from receiving monies due the State agency in reimbursement for paid Medicaid services and not reporting those payments to the agency. In particular, the law is aimed at absent parents of Medicaid eligible children, whose insurance policies make payment directly to them.

   This legislation offers recourse to providers that should have received payments that were made directly to the insured. Banks in Washington that honor such checks without both endorsements being present are subject to collection proceedings by any other party to whom payment should have been made.

HOUSE BILL No. 880 STATE OF WASHINGTON

AN ACT Relating to health care services; BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. Section 1, chapter 168, Laws of 1982 and RCW 48.44.026 are each amended to read as follows.

Checks in payment for claims pursuant to any health care service contract for health care services provided by persons licensed or regulated under chapters 18.22, 18.25, 18.29, 18.32 or 18.53 or 18.71 RCW, where the provider is not a participant under a contract with the health care service contractor, shall be made out to both the provider and the insured, jointly, to require endorsement by each: PROVIDED, that payment shall be made in the single name of the insured if the insured as part of his or her claim furnishes evidence of prepayment to the health care service provider: AND PROVIDED FURTHER, that nothing in this section shall preclude a health care service contractor from voluntarily issuing payment in the single name of the provider.

MODEL LEGISLATION E-3

Third Party Insurors Must Cooperate with State Medicaid Agency's Efforts to Identify Insurance Coverage Available to Medicaid Recipients

NEW YORK
OHIO

1. Abstract - Some States require all third parties to cooperate with any attempts by the State agency to identify liability that they may have for services received by Medicaid recipients and paid for by the State agency. Legislation of this type should include provisions that protect the third party from privacy problems by placing the liability stemming from any such actions on the State agency.

2. Impact of Model Legislation -

NEW YORK

New York's legislation, specifying privacy safeguards, allows the State agency to initiate data matches, immediately, with all of the licensed insurance plans in the State. It also facilitiates resource identification activities with several other insurance companies, because State and county staff now have access to payment and eligibility records for both clients and responsible relatives.

OHIO

Ohio's legislation authorizes the State agency to require third parties to participate in automated data matches, when they are equipped to do so. The immediate impact of this legislation was to overcome resistance from the State's retirement system to cooperating with the Medicaid agency in a data match to determine whether there were Medicaid recipients eligible for benefits from the retirement system's health insurance plan.

The State agency has used the law in conjunction with a TPL Supplemental Recovery Program (contingency fee contractor). Successful data exchanges have occurred with several private carriers. The legislation holds the private firms harmless in privacy considerations; however, private carriers have concerns of potential jeopardy in Federal privacy legislation taking precedence over the State law. This legislation may have useful applications in other States.

MODEL Legislation E-4

Payment of Cost Effective Health Insurance Premiums for Medicaid Recipients

MINNESOTA
NEW YORK

1. Abstract - Whenever an applicant for or recipient of public assistance or medical assistance has health insurance in force covering care and medical benefits covered under Title XIX, full or partial payment of the premium for such insurance may be made by the State agency when making such a payment is deemed appropriate pursuant to the regulations of the Department of Social Services.

2. Impact of Model Legislation - This legislation permits the State agency to continue a recipient's health insurance in force on a case by case basis. This has the effect of permitting the agency to pay premiums whenever it finds that doing so would be cost-effective to Medicaid. States that studied the problem generally found that many (and in some populations most) recipients who have insurance at the time of application cancel it upon being found eligible for Medicaid, because the program offers no incentive to continue paying premiums.

Summary of MINNESOTA Payment of Cost Effective Health Insurance Premium Statute

Eligibility Factors: Health Insurance Premiums

Cost Effective Health Insurance

MA funds are used to pay health insurance premiums determined to be cost effective to DHS. Premium payment is initially made by the local agency.

Premium payments for health insurance policies may be made by the MA program if:

(a) the policy has been determined to be cost effective by the Benefit Recovery Section (BRS); and

(b) without payment of the premium by MA, the policy would be terminated due to the recipient's financial inability to maintain the policy; and

(c) the premium payment was not used as an employment expense or to meet the client's spend-down.

A health insurance policy is considered to be cost effective if it appears that payment of the premiums would reduce MA expenditures by more than the cost of the premiums.

Health Insurance policies must be evaluated by the Benefit Recovery Section (BRS) for cost effectiveness whenever MA funds are used to pay the insurance premium. The cost effectiveness of a policy must be reevaluated by BRS whenever there is a change in the premium payment amount and/or the level of coverage provided by the policy. The following information must be submitted by the local agency to BRS to receive a determination of the cost effectiveness of a policy:

- Recipient's name(s)
- Recipient's age(s)
- Copy of actual and complete insurance policy
- The premium amount and premium payment schedule
- Information relating to any chronic medical condition(s) and/or utilization of medical care by the recipient (including nursing home benefits/expenses)
- Any extentuating circumstances, including estimated period of MA eligibility (if short term), or maternity leave from employment

- o Information relating to actual expenses paid by the insurance carrier during the previous contract period (if available). Determine if annual expenses paid by insurance exceed annual premium.

- o Identify if applicant/recipient is/will be enrolled in a Medicaid Demonstration Project for pre-paid health care.

It is critical that sufficient information be submitted with requests for cost-effectiveness review. Determinations are based on medical needs as well as premium expense; adequate information is required to make an accurate assesment of cost effectiveness.

Indemnity Insurance Policies

Indemnity insurance policies are not considered health insurance policies; premium payments may not be paid out of MA funds nor may they be used to meet a spenddown. These policies should not be referred to Benefit Recovery Section (BRS) for review of cost effectiveness.

Medicare Prepayment Plans

Medicare prepayment plans which have contracts with the Federal government to provide HMO services to Medicare beneficiaries, require cost effectiveness reivew by BRS. Changes in the cost of premiums and benefits available under these plans now necessitate a review by BRS.

Long Term Care Clients

Whenever a recipient resides in a long term care facility and has medical insurance which is determined to be cost effective, the premium shall be paid out of the MA assistance account and not from client income.

Client Spend-down

In a case where there is a six-month spend-down, the premium for medical insurance may be considered as part of the recipient's spend-down amount or the premium may be paid out of the MA assistance account for months that the recipient is eligible.

Recipient Reimbursement for Premium Payment

When an applicant is found eligible for MA and has paid for cost effective medical insurance premiums during the month of application and retroactive eligibility period, the recipient shall be reimbursed for the amount s/he paid for those premiums if:

- o the applicant/recipient was eligible for MA during the retro months;

- o the premiums were paid for cost effective health insurance; and

- o the premiums were not used to satisfy a spend-down or as an employment expense.

If a part of a premium is used to satisfy a spend-down requirement, then the reimbursement must reflect only the portion of the premium which was not used to satisfy the spend-down.

If the entire family is not eligible for MA but the premium coverage is for all family members, the reimbursement must reflect only the cost for the eligible family members. A breakdown of the premium amount for the eligible family members should be obtained. If that is not available, the premium amount should be prorated according to the number of covered persons.

Medicare Part A Premiums

Some individuals age 65 or older do not meet the requirements for premium-free hospital insurance under Medicare Part A. Persons who lack the quarters of coverage for entitlement to Part A or persons not enrolling when they become eligible for Part A, are required to pay a monthly premium for coverage.

Part A premiums are payable out of the MA account. Cost effectiveness review by Benefit Recovery Section (BRS) is not required.

Persons not enrolling timely for Part A may be charged a 10% penalty for each 12-month period of non-enrollment. Effective July 1, 1986, the late enrollment premium is limited to 20% above the monthly premium. Federal Financial Participation (FFP) for the premium payment is available at the Federal Medical Assistance Percentage (FMAP) rate rather than at the administrative rate.

The local agency should make payment from the "Medicare Payment Due Notice" received by the recipient each month. The check is made payable and sent to: HCFA Medicare Insurance, Medicare Premium Collection Center, Department 98081, Louisville, Kentucky 40298.

Medicare Part B Premiums

Medicare Part B premiums may not be paid out of MA funds for persons not entitled to Supplemental Security Income (SSI) or Minnesota Supplemental Aid (MSA) benefits. Persons receiving SSI or MSA and Medical Assistance who are eligible for Medicare Part B, will be covered under the State Buy-In Program referenced in Section IV-D.

Medicare and Prepayment Plans

Persons covered by Medicare Part B are eligible to enroll in Medicare Prepayment Plans. Medicare Prepayment Plans include Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) that have contracts with the Federal government to provide services to Medicare beneficiaries. The premium paid to the prepayment plan is for deductibles and coinsurance, and for benefits in addition to those covered by Medicare. It is not the premium for Medicare Part B medical insurance.

Some prepayment plans will not pay for services outside the plan system; these denied services do not quality for Medical Assistance reimbursement.

The Health Insurance cost effectiveness review by BRS is required for Medicare prepayment plans. Premiums may be paid from MA funds for those Medicare-covered persons when cost effectiveness has been determined.

NEW YORK Statute

Group Health Insurance Benefits; Conditions of Eligibility

Notwithstanding any other inconsistent provision of law and to the extent permissible under federal law, any applicant for or recipient of home relief or aid to dependent children who is or becomes employed and whose employer provides group health insurance benefits, including benefits for a spouse and dependent children of such applicant or recipient, shall apply for and utilize such benefits as a condition of eligibility for home relief or aid to dependent children. Such applicant or recipient shall also utilize such benefits provided by former employers as long as such benefits are available. The Department shall promulgate regulations to determine the eligibility requirements of those applicants and recipients who have more than one employer offering group health insurance benefits.

The provisions of this section shall apply to such applicants upon their initial certification for aid to dependent children or home relief and to such recipients upon their recertifications for such assistance following the date on which this section becomes effective. The cost of premiums paid by such applicants or recipients for such coverage shall be deducted from such applicant's or recipient's earnings as an expense incident to his employment, in addition to any other expenses allowed pursuant to the provisions of section 131-I of this article.

MODEL Legislation E-5

Adjudicated parents must execute and deliver any instruments necessary to assure the timely payment of the dependent's(s') health insurance claims.

NEW YORK

1. Abstract - This legislation requires the adjudicated parent to execute and deliver any forms, notices, document or other instruments necessary to assure the timely payment of any health insurance claims for his/her dependent(s).

2. Impact of the Model Legislation - This legislation goes beyond the normal requirement that court ordered health insurance coverage be provided by making provisions for directing the dependent's(s') health insurance payments. The adjudicated parent is required to supply instruments not only to prove to a provider that coverage exists, but also to allow the provider to bill the available third party (claims forms). Further, in cooperation with its IV-D unit, State Third Party is defining one of these instruments necessary to be an assignment of all health insurance payments for this/these dependent(s) to the provider of service. This prevents the adjudicated parent from receiving the money thereby reducing IV-D's violation workload.

Model Support Enforcement Through Employer Withholding Requirements

MINNESOTA

1. Abstract - This law requires the obligor to name the minor child as beneficiary on any health and dental insurance plan that is available to the obligor on a group basis or through an employee or union. If the court finds that dependent or dental insurance is not available to the obligor through an employer or union, or that the group insurer is not accessible to the obligee, the court may require the obligor to obtain dependent health or dental coverage, or to be liable for reasonable and necessary medical or dental expenses of the child.

   The Office of Child Support Enforcement regulations published in the Federal Register on October 16, 1985, require the State IV-D agency to petition the Court or Administrative authority to include health insurance coverage in the support order if the absent parent has access to employment related or other group insurance. Some States require legislation to implement the Federal regulations. This model legislation is being provided to assist States in complying with the requirement.

MEDICAL SUPPORT STATUTES

Minnesota Statutes, section 518.171

Subdivision 1. ORDER - The obligor shall name the minor child as beneficiary on any health and dental insurance plan that is available to the obligor on a group basis or through an employer or union.

If the court finds that dependent health or dental insurance is not available to the obligor on a group basis or through an employer or union, or that the group insurer is not accessible to the obligee, the court may require the obligor to obtain dependent health or dental insurance, or to be liable for reasonable and necessary medical or dental expenses of the child.

Subdivision 2. SPOUSAL COVERAGE - The court shall require the obligor to provide dependent health and dental insurance for the benefit of the obligee if it is available at no additional cost to the obligor and in this case the provisions of this section apply.

Subdivision 3. IMPLEMENTATION - A copy of the court order for insurance coverage shall be forwarded to the obligor's employer or union by the obligee or the public authority responsible for support enforcement only when ordered by the court or when the following conditions are met:

a. The obligor fails to provide written proof to the obligee or the public authority, within 30 days of receiving effective notice of the court order, that the insurance has been obtained or that application for insurability has been made;

b. The obligee or the public authority services notice of its intent to enforce medical support on the obligor by mail at his or her last known post office address; and

c. The obligor fails within 15 days after the mailing of the notice to provide written proof to the obligee or the public authority that the insurance coverage existed as of the date of mailing.

Subdivision 4. EFFECT OF ORDER - The order is binding on the employer or union when service under 3 above has been made. Upon receipt of the order, or upon application of the obligor pursuant to the order, the employer or union shall enroll the minor child as a beneficiary in the group insurance plan and withhold any required premium from the obligor's income or wages. If more than one plan is offered by the employer or union, the child shall be enrolled in the insurance plan in which the obligor is enrolled or the least costly plan otherwise available to the obligor that is comparable to a number two qualified plan. A number two qualified plan as defined in Section 62E.06 is a plan with a deductible that does not exceed $500 per person annually and will pay for at least 80% of the cost of covered services provided. The plan must limit out of pocket expenses to $3000 per person. The insurance coverage for a child under 5 below shall not be terminated except as authorized in section 5.

Subdivision 5. ELIGIBLE CHILD - A minor child that an obligor is required to cover as a beneficiary pursuant to this section is eligible for insurance coverage as a dependent of the obligor until the child is emancipated or until further order of the court.

Subdivision 6. INSURER NOTICE - The signature of the custodial parent of the insured dependent is a valid authorization to the insurer for purposes of processing an insurance reimbursement payment to the provider of the medical services. When an order for dependent insurance coverage is in effect and the obligor's employment is terminated, or the insurance coverage is terminated, the insurer shall notify the obligee within 10 days of the termination date with notice of conversion privileges.

Subdivision 7. RELEASE OF INFORMATION - When an order for dependent insurance coverage is in effect, the obligor's employer or union shall release to the obligee or the public authority, upon request, information on the dependent coverage, including the name of the insurer. Notwithstanding any other law, information reported pursuant to section 268.121 shall be released to the public agency responsible for support enforcement that is enforcing an order for medical or dental insurance coverage under this section.

Subdivision 8. OBLIGOR LIABILITY - The obligor that fails to maintain the medical or dental insurance for the benefit of the children as ordered shall be liable to the obligee for any medical or dental expenses incurred from the date of the court order. Proof of failure to maintain insurance constitutes a showing of increased need by the obligee pursuant to section 518.64 and provides a basis for a modification of the obligor's child support order.

Subdivision 9. APPLICATION FOR SERVICE - The public agency responsible for support enforcement shall take necessary steps to implement and enforce an order for dependent health or dental insurance whenever the children receive public assistance, or upon application of the obligee to the public agency and payment by the obligee of any fees required by section 518.551.

Minnesota Statute, section 518C.02

Subdivision 3. DUTY OF SUPPORT - "Duty of Support" means a duty of support, whether imposed by law or by order, decree or judgement of a court, whether interlocutory or final, or whether incidental to an action for divorce, separation, separate maintenance or otherwise and includes the duty to pay arrearages of support past due and unpaid, as well as the duty to provide medical, health, or dental insurance or support.